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REPORT ON THE FINANCIAL RESOURCES OF MAJOR HOSPITALS IN BOSTON

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TABLE OF CONTENTS

EXECUTIVE SUMMARY		i
INTRODUCTION		1
1:	How profitable are the Boston hospitals?	2
2:	How much cash did the hospitals generate over the period 1984-1992, after operating expenses were met?	11
3:	Where did the $3.6 billion in cash sources generated by the twelve hospitals over 1984-1992 go?	13
4:	What are hospital affiliates, what are their resources, and how do they get those resources?	16
5:	What was the nature of the $2.2 billion in capital spending over the period 1984-1992? What are the committed additional $500 million going into? Is all of this capital expenditure "needed"?	19
6:	How will hospitals keep their beds full and/or pay off their long term debt?	24
7:	What role does philanthropic giving play in producing all of these buildings? Does it lower the cost of care to patients? Does philanthropy enable the weaker hospitals to maintain buildings and services that they might otherwise not be able to provide?	28
8:	Are the financial resources described here--cash from operating activities, philanthropy, discretionary cash balances, and capital assets-- shared equally among the twelve Boston hospitals, relative to their size or patient output?	29
9:	Are the hospitals with the strongest financial position also the hospitals with the greatest commitment to the local community (Boston), to the uninsured, and to minorities?	32
10:	What specialties are disproportionately used by the uninsured?	38
CONCLUSION		40

Report on the Financial Resources of Major Hospitals in Boston

Nancy M. Kane, D.B.A.

-Executive Summary-

Background: Declining Admissions for $1 Billion in New Inpatient Facilities

Over the last decade, both statewide and nationally, hospital patient days and admission rates have been declining. Yet, from 1984-92, Boston hospitals invested close to $1 billion for replacement and renovation of inpatient capacity. This expenditure seems hard to justify both strategically and financially, particularly in the context of Massachusetts's hospital costs, amongst the highest in the nation.

There are two common arguments put forth to justify the high level of capital investment in inpatient facilities and equipment. One is the "forced by state policy" argument. Here, blame is laid at the doorstep of state policy makers who have made hospital payments increasingly volume-driven. In a period of excess capacity, hospitals must fight to attract volume and revenues away from each other. Hence they try to outdo each other in having the most updated equipment and facilities. The flaw in blaming the state is that the hospitals themselves, particularly the large Boston teaching hospitals, played an influential role in forming state payment policy.

The second argument is the "regionalization" argument. Here, the major tertiary hospitals in Boston argue that they must maintain the most up-to-date facilities and equipment because they are doing procedures that community hospitals cannot do. However, this argument is weakened by the fact that a large proportion of what the "tertiary" hospitals in Boston do are simple procedures such as hernia repairs and gall bladders, the "bread and butter" of the community hospitals. Nearly two-thirds of the patients treated in Boston hospitals are not Boston residents; many are bypassing a local community hospital to have their general surgery done "downtown."

Managed care's increasing role is likely to divert many of these patients back to their less expensive, community hospitals. To protect themselves, Boston hospitals can be expected to become ever more aggressive in seeking the suburban community hospital patients not constrained by managed care.

Hospitals Have Accumulated Enormous Cash Reserves

Boston hospitals vary widely in how much accumulated discretionary cash they have. Children's Hospital is the clear leader with $329 million. Behind Children's but still in enviable positions are Brigham and Women's Hospital with $233 million, Massachusetts General Hospital with $144 million, and New England Deaconess with $101 million. At the other end of the spectrum are Carney with $29 million and BCH with none.

Multi-year Cash Flow Analysis is a Reliable Indicator of Financial Performance

Accumulated cash is measured using "multi-year cash flow analysis." Multi-year cash flow analysis is the preferable method of assessing hospital financial performance. This method is reliable, because cash is not estimated, it cannot be hidden or misleadingly labeled, and over the long term, it is an accurate and objective perspective of hospital financial performance.

Using the multi-year cash flow analysis method, from 1984-92, the Boston hospitals (and their parent corporations) accumulated an unusual amount of cash, beyond what they needed for current operating purposes. Allowing for working capital accounts which meet industry standards, the hospitals had excess discretionary cash balances totalling about $1 billion. This is 21% of all cash generated from patient care, philanthropy and borrowing.

Boston Hospitals' Varying Degrees of "Financial Health"

Using a variety of financial indicators, Boston hospitals vary widely in their financial "health." Generally speaking, the strongest hospitals are Children's Hospital, MGH and BWH. The weakest hospitals are Boston City Hospital, Faulkner and Carney. These latter three hospitals have been experiencing the highest reductions in patient volumes and are the most vulnerable to the aggressive marketing tactics of the other hospitals.

The middle group is comprised of New England Medical Center, Beth Israel, New England Deaconess, Boston University Medical Center and St. Elizabeth's. This group is also vulnerable to inpatient volume losses, due to their aggressive and highly leveraged capital investments.

Hospitals Can Manipulate Their Income Statements to Appear "Poor"

Multi-year cash flow analysis is not the only way to measure financial performance. Hospitals prefer to focus on their "income statement" results, which are subject to extensive management discretion. The income statement is focussed upon for public reporting purposes by the hospitals. Income statements are easily manipulated by management to distort the perception of financial performance. For example, financial performance can be manipulated on the income statement through the use of arbitrary estimates for future settlements with third party payers (a reserve account for money the hospital has received but which the hospital claims it might have to pay back).

Income statement manipulation can adhere to "Generally Accepted Accounting Principles" and still leave management vast discretion as to how much income it "wants" to report in a particular year:

▸ For example, using "Generally Accepted Accounting Principles," Massachusetts General Hospital could have chosen a 1991 "bottom line" anywhere from $1,172,000 (the profits

"before adjustments" it showed on its 1991 income statement) to $46,000,000.

There are also instances in which hospital income statements have violated industry accounting standards, resulting in misleading information:

▸ MGH failed to reveal that it had changed an accounting method on its 1991 financial statements; the change reduced income by $15,000,000.

▸ New England Deaconess Hospital's 1992 income statement is inconsistent with the Hospital Audit Guide by reporting "charity care" as an expense, understating income by several million dollars.

Another method the hospitals have utilized to understate their incomes is to remove non-operating revenues (philanthropy and investment income) from the hospitals' income statements. This can be achieved through the simple device of creating a "parent corporation" for the hospital; revenue-generating assets are diverted to the "parent."

▸ For example, in 1991, the Children's Hospital parent corporation (a separate corporation from Children's Hospital) collected over $45 million in revenue, including $21,700,000 in interest and dividends, $8,100,000 gains on securities sales, $6,300,000 in philanthropy, and $4,900,000 hotel and restaurant revenues. None of this income appeared on the Children's Hospital income statement. Roughly $40 million of the revenue was generated by $437 million in assets, most of which was cash and securities (stocks and bonds).

Not all of Boston's hospitals steer income-producing assets into their parent corporations. For example, Beth Israel Hospital and New England Baptist Hospital have not engaged in this practice to any appreciable extent.

Boston Hospitals and Philanthropy: the More the Philanthropists Give, the More the Patients Pay

Philanthropy and income from investment portfolios are a larger source of the hospitals' cash than income from patient care, teaching and research.

The Boston hospitals which have benefitted the most from philanthropy are those which were financially the strongest to begin with. Whether a hospital uses philanthropy or debt to finance capital construction, it seeks to recover its capital investment from patients and research grants. Thus, depreciation expenses, which are substantial, are charged to patients, whether a building was "given" by benefactors or paid for with borrowed funds. Because an income statement account can make a hospital look poor, even while its parent is rich, donors are often led to believe that without their funds, the hospital is on the verge of defaulting on its mission.

Boston Hospitals' Commitment to the Local Community

One measure of a hospital's commitment to the local community is to examine the hospital's patient characteristics: whether they are uninsured, whether they are Boston residents, and whether they are minorities.

BCH, Carney and MGH show the highest relative commitment to the uninsured. The lowest relative commitment to uninsured patients is at New England Deaconess, Faulkner and Children's.

BCH, Carney and Faulkner are the only hospitals drawing more than half their patients from Boston. At the other end of the scale, only 22% of Children's Hospital patients are from Boston, and only 15% of New England Deaconess patients are from Boston.

The hospitals with the highest relative commitments toward minority patients are BCH, BWH, Carney, University and Beth Israel. The hospitals with the lowest relative commitments are New England Medical Center, New England Deaconess and MGH.

Consistent with earlier findings from the Rate Setting Commission, the uninsured utilize certain specialties more than their numbers would otherwise justify. "Overuse" of these particular specialties appears to be related to a lack of primary care.

Conclusion and Recommendations

The twelve hospitals in Boston accumulated $1 billion in discretionary cash, and they spent $2.2 billion on new property, plant and equipment in the last nine years. Even though private, taxpayer-supported hospitals are community assets, public input into how they spend their resources is limited. There is no doubt that hospitals make contributions to their communities, but it is less clear whether these contributions reflect their communities' greatest needs. Communities are information-poor in assessing the financial capacities of these community assets, since hospitals have such wide latitude in determining what "profits" they wish to show in any particular year. Unlike for-profit corporations, the hospitals do not have shareholders to "police" corporate income statements. The result is income statements which are highly misleading when compared to actual accumulation of discretionary cash and when measured against professional accounting standards. Improved financial reporting practices are necessary if we want to reach a minimum level of acceptable public accountability for the private, taxpayer-supported hospitals.

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INTRODUCTION

What are the financial resources of hospitals in the city of Boston? What is their financial capacity to address community needs of the city?

These research questions were intended to establish a factual basis for understanding the financial condition and local community (Boston) commitment of the twelve non-specialty teaching hospitals providing acute care services within the City of Boston. The twelve hospitals are Beth Israel, Boston City, Brigham and Women's, Carney, Children's, St. Elizabeth's, Faulkner, Massachusetts General, New England Baptist, New England Deaconess, New England Medical Center, and University Hospital. The purpose of establishing the factual base was to encourage public understanding of hospital finances, and thereby support public accountability of these nonprofit institutions. The hospital payment system established in 1990 embraced the role of private markets over government intervention in the health system; the market philosophy reinforces the need for more and better information describing hospital performance. **This analysis intends to contribute to the information base needed by the public to assure appropriate allocation of resources by hospitals.**

In an attempt to simplify a very complex topic, the format of this report is "question and answer." These questions have evolved from what the author has been asked over the period of developing this report. Numerous presentations of the information collected for this report were made to representatives of hospitals, neighborhood health centers, government

agencies, community advocacy groups, and business leaders to assure accuracy and relevance of the report (see Appendix A for list). Their input was extremely valuable in helping to form the final product; however any omissions or errors belong solely to the author.

QUESTIONS

Question 1: How profitable are the Boston hospitals?

By traditional comparative standards, and using the income statement method of measurement only, the Boston hospitals were not very profitable over the last nine years. However a number of practices the Boston hospitals use undermine the meaningfulness of reported operating profits. These practices include:

a. Use of "estimates" that are substantial portions of the income statement and that are subject to management discretion.

b. Departing from the Hospital Audit Guide by counting charity care as a direct "expense."

c. Diversion of substantial philanthropy and income-generating assets, so that these amounts do not show up on hospital income statements but instead are "run through" affiliated corporations.

Figure 1, "Mean Operating Margins," shows the mean operating profits (operating revenues minus operating expenses) of the 12 hospitals over the period of analysis, compared to

national and northeastern regional hospital profits. The Boston hospitals average a significant drop in operating profits between 1986 and 1989, and then a dramatic improvement over the period 1990-1992. **Table 1** shows the nine year cumulative income statement of the 12 hospitals; over the period 1984-1992, the Boston hospitals made a cumulative operating margin (operating income/operating revenues) of only 1.29%.

a. Use of "Estimates"

The credibility of reported operating profits is undermined by the fact that a significant proportion of both revenues and expenses are estimated each year. The estimates are a matter of management discretion. The amount of the estimate significantly affects what is reported as operating profits; for the large Boston hospitals, those estimates have tended to understate profits.

For instance, Massachusetts General Hospital's (MGH) income statement for 1991 had the following components (this combines what appeared on the income statement and what was reported in a footnote to that statement filed with the Rate Setting Commission). Amounts that are asterisked (*) includes substantial estimates by management, rather than actual experience.

		1991
Gross charges from services to patients		614,318,000
Less: Charity Care	(23,498,000)	
Contractual allowances	(124,377,000)*	
Net Patient Service Revenue		466,443,000
Other Operating Revenues:		
Direct and Indirect recoveries for research		137,712,000*
Other Revenues		24,112,000
Total Operating Revenue		628,267,000
Operating Expenses:		
Employee compensation and benefits		306,225,000*
Supplies and other expenses		157,431,000
Depreciation		39,812,000
Interest		17,227,000
Provision for doubtful accounts		11,852,000*
Direct costs on restricted fund activities (largely research)		94,548,000
Total Operating Expense		627,095,000
Income from Operations before adjustments		**1,172,000**
Adjustments to prior years' estimates for settlements with third-party payers		19,778,000*
Adjustment to accruals for employee benefits		(15,000,000)*
Income from Operations		**5,950,000**

Clearly, there are significant portions of this income statement which are estimates. Two of the larger ones are in the "adjustments" made to income from operations: one for prior years' estimates for third party settlements, and one for estimates related to post-retirement benefits.

The first adjustment represents amounts that were paid by third party payers (i.e. Medicare, Blue Cross) to the hospital in years before 1991, but were not recognized as revenues because of uncertainty concerning the allowability of those payments, as determined by management. Instead of being called revenues, an income statement account, they were first classified as reserves, a balance sheet liability account. When it was finally determined years later that the hospital could keep those payments, the reserves were reversed and recognized as revenues.

It appears that MGH was generally conservative in estimating payment allowability; the history of favorable prior years' settlements settled over the last four years were as follows (reported in the year of settlement):

	Amounts in Reserves that are Reversed, Become Revenues	Balance Still in Reserves
1989	$9,570,000	$59,152,000
1990	$2,878,000	$53,141,000
1991	$19,778,000	$60,589,000
1992	$36,187,000	$49,468,000

Note that reserves in 1991 actually grew by $7 million over 1990 balances, even though we know that $19 million in reserves were taken from the 1990 reserve balance and recognized as 1991 revenues. This suggests that close to $26 million (the $19 million favorable settlement plus the $7 million increase in reserves) was received in payments in 1991 from third parties, but the $26 million was added to reserves rather than recognized as revenues.

Thus the range of managerial discretion over reported operating profits in 1991 was between the $1.2 million "income from operations before adjustments," and $46 million. In other words, adding 1991 "reported" operating income of $1.2 million plus the $19.7 million in prior years' "favorable" third party adjustments, plus the $26 million in third party payments in 1991 (that management decided not to recognize as revenue), adds up to a "potential" profit of over $46 million.

Looking at all of the Boston hospitals in the context of this "estimation" issue -- reserve and prior year adjustments -- we see that this phenomenon affected the Boston hospitals' cumulative reported profits substantially. **Figure 2** shows the annual operating income and nonoperating revenue trends over this period. Operating income in 1992 totalled close to $100 million, the highest amount of the nine year period. Most of this operating income, around $80 million, was disclosed as having come from prior years' favorable settlements, leaving only $20 million in operating income pertaining to services delivered in 1992.

In other words, 80% of the "profits" in 1992 were actually "earned" in prior years. What was actually "earned" in 1992 but reserved rather than reported as revenues? Although hospitals did not disclose how much 1992 revenue was reserved against estimated third party liabilities, the addition to the reserve liability in 1992 was $40 million; thus it appears that $40 million of 1992 "revenues" were set aside as estimated reserves. That $40 million addition to reserves is twice as large as the $20 million that hospitals recognized as net income related to 1992.

Revenues are not the only income statement element that management has the discretion to estimate; there is also considerable latitude in the ability to estimate expenses.

Returning to the MGH Hospital example, another adjustment to operating income is management's estimate of an expense: the accrual of post-retirement health benefits. There are two issues related to this "adjustment" that might mislead the outsider trying to find a precise number for the hospital's operating income. One is that the accrual is an estimate; the amount MGH actually will owe depends upon such considerations as how long current employees live, work at MGH, and how sick they get between retirement and death, which could relate to a period 20 years from now. Obviously the assumptions made to come up with an estimated accrual for post-retirement health benefits can significantly affect the end value. Second, in this instance, this adjustment represents a change in accounting method, which should have been reported after operating income, and not as an adjustment to operating income that is lumped in with changes in third party estimates. The format used by MGH in 1991 to report the change in accounting method was misleading; it was not revealed as a change in accounting method until the 1992 statements.

b. Departure from the Hospital Audit Guide

Another recent example combining departure from the Hospital Audit Guide with an unusual and misleading expense estimate is in the 1992 income statement of the New England Deaconess Hospital. In 1992, the hospital reported an operating expense of $18,971,000 in "uncompensated care"; this appears to include both charity care as well as the provision for

bad debt.[1] The Hospital Audit Guide indicates that only the provision for bad debts, and not the amounts provided for charity, should be reported as an expense on the income statement. Since the Hospital Audit Guide provides the standard followed by most hospitals, the Deaconess' reported income from operations appears to be understated by several million dollars.

Thus, the credibility of hospital operating profits is undermined by both conservative accounting practices and, in some cases, a tendency not to follow the accounting practices recommended in the Hospital Audit Guide or generally accepted accounting principles.

c. Diversion of philanthropy and income-generating assets away from the hospital, to its corporate affiliates.

Hospital reported "surpluses" are also subject to a high degree of managerial manipulation. Much if not all of a hospital's investment returns and donations may not be reported in the hospital income statement at all, even though they are often far greater than operating profits or losses.

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[1]The corresponding 1991 amount of $15,631,000 is higher than what was reported in 1991 as bad debt, which was only $6,324,000. In addition, in a community benefit accounting Deaconess provided to the Mayor's Health Care Commission, for a period pertaining to 1992, the hospital reports only $9.9 million in bad debt provisions. I thus conclude that the 1992 $18 million figure reported in the audited financial statements includes more than the bad debt provision permitted by the Hospital Audit Guide.

A hospital's "surplus" combines operating income, which is that earned from patient care, teaching, and research, with nonoperating revenues, which are revenues received from donors and investment income. As **Table 1** shows, over the 9 year period 1984-1992, operating income totalled $258 million dollars, nonoperating revenues totalled $340 million, and the surplus, or sum of operating income and nonoperating revenues, totalled $598 million. Over half the surplus came from donations and investment income. Philanthropy and investment funds are larger sources of cash to meet hospital financial requirements than are operating profits earned by providing patient care, teaching, and research.

As **Figure 2** shows, the trend in nonoperating revenue is somewhat erratic. There are three factors influencing that trend. One factor is fluctuations in the actual amount of donations and investment income earned. This might vary with the hospital's capital cycle, i.e. if the hospital has accumulated a large "funded depreciation" balance, it earns investment income; when it spends the balance on capital projects, investment income drops.

However, a second and far more important factor is where those revenues are recognized; over the mid- to late-eighties, the fund-raising and "funded depreciation"-type investment activities of some hospitals were transferred out of the hospital entity and into an affiliated "parent" or "foundation" entity. The associated "nonoperating revenues" thus disappear from the hospital entity. Consolidated income statements, in which the hospital and all related entities' performances are combined, can show results dramatically different from those on hospital income statements alone. For two hospitals that produced consolidated 1991 and

1992 statements, the reported surpluses of the consolidated entities were from 1.7 to 4.5 times greater than the surpluses reported by the hospital entities alone.

Until and unless donations and investment income are transferred to the hospital entity as nonoperating revenues, they will not run through the hospital income statement. However, the hospitals also have a technique for transferring these sums from an affiliated corporation to the hospital entity without the transferred sum showing up as "income" on the hospital's income statement. When these amounts are transferred to the hospital, they are recognized and labeled as "capital donations"; capital donations are directly credited to the hospital fund balance or its equity, and they are not run through the income statement.

A third factor causing variation in the reporting of nonoperating revenue, both over time and across hospitals, is the new Hospital Audit Guide, which no longer requires that hospitals classify investment income and unrestricted donations as nonoperating revenues. Rather, the new Guide requests hospitals to classify the former nonoperating revenues as either 1) "central" to their main mission, in which case they are considered "revenue"; or 2) "peripheral" to their main mission, in which case they are considered "gains" (reported after the operating income section of the income statement). Beginning in 1992, several hospitals started recognizing investment income and donations as "revenues," no longer separately distinguishable from patient care and other sources of operating revenues.

In sum, the question "How profitable are the Boston hospitals?" yields answers made up of

factors subject to considerable management discretion; these factors include use of "estimates," departures from conventional accounting principles, failure to disclose changes in accounting methods, and broad control over where and how "nonoperating revenues" are reported. The sum of these factors is a serious income statement credibility problem.

Question 2: How much cash did the hospitals generate over the period 1984-1992, after operating expenses were met?

A cash flow statement addresses the questions "Where did the cash come from?" (cash sources) and "Where did the cash go?" (cash uses). Here, it may be helpful to think of cash sources and uses as funds generated and used above and beyond payment for operating expenses. **The short answer is that Boston hospitals generated $3.6 billion in cash between 1984-1992.** The sources of cash are described below.

With annual income statement trends clearly not as meaningful as one might hope, we turn to the multiyear cash flow statement analysis which provides a clearer picture of financial performance than does the income statement analysis. The objectivity of reporting improves with cash flow statement analysis because cash is not an estimate; cash flow statements, when viewed over a multiyear period, provide an accurate and objective long-term perspective of hospital financial performance.[2]

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[2]For further elaboration on this topic, see Kane, NM. "Profits: A Misleading Measure of Financial Health." Journal of American Health Policy, June/July, 1991

Table 2 provides an abbreviated picture of the cumulative sources of cash generated by the 12 Boston hospitals over the 9 year period 1984-1992. Operating activities (which combine net cash results from the income statement--operating income plus noncash adjustments such as depreciation-- with the cash generated or required for working capital and third party reserves supporting operations) generated $1.6 billion, or 43% of total cash sources over the 9 year period. **Nearly two-thirds of operating cash came from noncash charges on the income statement** (mostly depreciation, which is a noncash expense). **Working capital generated an additional $205 million;** this can be attributed to large increases in current liabilities in excess of increases in current assets. Compared to four other states on which I have done cash flow analysis, Boston teaching hospitals are unusual in generating cash from working capital. The main difference relates to the Boston hospitals' greater tendency to set aside revenues as reserves for estimated third party liabilities, described earlier.

Another 16% of cash sources comes from donations, investment income, and transfers from related affiliates. These affiliate transfers generally represent resources generated from donations and investment income on funded depreciation or other investments that the hospital may have transferred previously to the affiliate; alternatively, the affiliate directly raised the funds on behalf of the hospital.

Finally, 41% of total cash sources came from increases in long-term liabilities, in particular, long-term debt associated with the financing of large capital projects. 1992 was a record year in the increase of long-term debt for capital projects; the net increase in long-term debt

in 1992 was $457 million, representing one third of the entire 9-year total increase in long-term debt.

Question 3: Where did the $3.6 billion in cash sources generated by the twelve hospitals over 1984-1992 go?

The hospitals spent $2.2 billion on property, plant and equipment. There was also a cumulative increase in board-designated and working capital cash of $767.5 million, generated for discretionary purposes. At the end of the 1984 - 1992 period, the hospitals had approximately $1 billion in discretionary cash accounts, beyond the "industry norm" of 20 days of operating expenses.

Table 3 describes cash uses over the same period, or "where the $3.6 billion went." Most of it (60%) went into property, plant, and equipment. As **Figure 3-A** shows, there has been a steady upward trend in capital expenditures over the 9 year period. While the average rate of growth in capital expenditures over the period 1984-1991 was 16% per year, the jump in capital spending in 1992 over 1991 was 33%, or nearly $100 million higher. As of September 30, 1992, the hospitals had committed to an additional $610 million in capital expenditures through 1995. In addition to commitments, another $4-500 million is "planned," according to various sources.[3] (Question 5 below addresses the nature and "need" for these capital expenditures.)

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[3]Boston Business Journal, 1/27/92. "Area's Largest Construction Projects. The List."

Another 17% of cash uses were to set aside cash reserves to meet ongoing long-term liabilities. This cash is classified as "trustee-held." The largest liabilities for which these cash reserves are established are for long-term debt related to capital projects. The cash will be used either for the construction project or to meet the related debt-service requirements. Trustee-held cash also includes funds set aside for self insurance liabilities and other contractually established liabilities requiring cash reserves.

Increases in board designated assets, which are discretionary in the sense that the hospital board can designate their ultimate use (and can change its mind), absorbed 6% of cash. However, accounting practices have complicated the identification of board-designated, or "discretionary" cash resources of hospitals. For instance, two hospitals (Brigham, St. Elizabeth's) combine board designated assets with donor-restricted and trustee-held assets under the "current assets whose use is limited" designation. Other hospitals have transferred most of their board designated and other unrestricted investments to other entities, discussed further below.

Increases in "current assets whose use is limited," combined with changes in the current "cash and cash equivalents" constitute working capital cash. This category absorbed 15% of total cash generated. Since hospitals vary in how they report the distinctions between board-designated and working capital cash, it is more revealing to use an industry standard to determine how much cash is probably required for working capital, and to assume the rest is available for whatever use management and trustees choose. According to the Health Care

Financial Management Association's industry financial guide, generally 20 days of operating expense (excluding depreciation) is more than adequate for working capital.[4] In 1992, 20 days of operating expenses came to 13% of total working capital and board-designated cash balances combined. The remaining 87% of the balance, representing just over $1 billion in 1992, was cash available for whatever purposes management and the board might choose. Going back to **Table 3**, then, it appears that most if not all of the cumulative increase in board-designated and working capital cash (totalling $767,518,000) was generated for discretionary purposes. Following this logic, another way of putting it is that roughly 21% of the cash generated by patient care, philanthropy, and borrowing was put in a discretionary cash account that was not needed for current operating purposes. By 1992, the discretionary cash balance was around $1 billion.

The discretionary $1 billion is very unevenly distributed amongst the Boston hospitals. Children's Hospital is at one extreme, with $329 million cash in excess of 20 days operating expenses. Brigham and Women's ($233 million), MGH ($144 million), and New England Deaconess ($100 million) are "behind" Children's but are still in very enviable positions. At the other extreme is Boston City Hospital, with no cash in excess of the industry norm. **Figure 3-B** shows "1992 Cash Balances in Excess of Industry Norm" for all 12 hospitals.

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[4]Cleverly, W.O., Hospital Industry Financial Report, 1985-1989. Healthcare Financial Management Association. (1990).

Question 4: What are hospital affiliates, what are their resources, and how do they get those resources?

"**Affiliates**" are other for-profit and not-for-profit corporations which are either "parents" of the hospital corporate entities or "corporate siblings" of the hospital entities. They **account for more than one quarter of all hospital financial resources (in 1991).** Since reporting of affiliates is not standardized or easily located, it is possible that there are affiliates not included in this analysis.

Figure 4 provides a snapshot of the assets in place in 12 Boston teaching hospitals as of 9/30/91. The approximately $5.5 billion in assets are reported under four broad categories: unrestricted assets of the hospital entity, $3.5 billion; donor-restricted assets of the hospital entity, another $.5 billion; assets of $1.3 billion in related affiliates; and assets of around $.25 billion (an estimate) in "unrelated" affiliates. The assets reported within the hospital entity's financial statements represent only 72% of total assets; the rest are reported under "related" and "unrelated" affiliates. (To the extent there are more related and unrelated affiliates we have not found, the 72% figure would be even lower.)

Related affiliates report financial information in IRS Form 990's, as well as in "consolidated" hospital financials when available (usually when the hospital is borrowing money in the bond market). These related affiliate assets have grown by roughly $1 billion since 1984. Appendix B provides hospital-specific charts of hospitals and their related entities.

The assets in related entities get there in two ways, generally. One is for the affiliate to get assets directly from the hospital, either as a transfer or a loan. For instance, Children's Hospital transferred over $20 million of its "funded depreciation" (a board-designated cash account) to its parent, Children's Medical Center, in both 1991 and 1992. In addition, it loaned the parent another $32 million dollars. Turning to the Children's Medical Center (the parent) income statement for 1991, one sees that in addition to hospital transfers, the parent entity earned almost $45 million dollars in revenues. $6.3 million of the parent's revenues came from donations (unrestricted and restricted gifts); the remaining $39 million represented returns on investments in real estate and marketable securities. Other hospitals like Brigham and Womens and New England Medical Center have parent organizations that are primarily fund raisers; the bulk of assets generated by fund-raising remain in the parent, with small annual transfers to the hospital and to other related entities as determined by either donors or management.

The "unrelated" affiliates category of **Figure 4** represents buildings owned by organizations "independent" of the hospital to which it is rented. These buildings are almost totally debt-financed, and they hold noncancellable operating leases signed by the hospital. For instance, the MGH signed noncancellable operating leases for use of buildings and equipment at an annual rent of $29 million in 1992, and rising to $34 million/year through 1997. Apparently these operating leases enable hospitals involved in large government research projects to collect overhead payments for space that they would be unable to collect if they

owned the buildings themselves.

Figure 5 describes a consolidated picture of 1992 ending cash balances of each hospital, combining related affiliate and hospital cash balances. It describes five categories of cash: working capital cash (cash reported in the "current asset" section of each hospital's and related entities' balance sheet), board designated cash (reported in the "noncurrent asset" section of the balance sheet of the hospital, as well as in affiliated entities), trustee held cash (also in the "noncurrent asset" section, generally only in the hospital's balance sheet), donor restricted cash (often reported in the affiliated entities, although research grants for some hospitals remained within the hospital entity), and unconsolidated affiliate cash (reported in affiliates in 1991; 990's not yet available for 1992). The cumulative total of each category is below:

Working capital cash:	$ 559,367,000
Board designated cash:	$ 645,020,000
Trustee held cash:	$ 852,299,000
Donor restricted cash:	$ 578,942,000
Unconsolidated affiliate cash (1991):	$ 90,500,000
TOTAL CASH, 1992	$2,726,128,000

This reporting complexity--multiple entities, varying ways to consolidate the reporting entities, and no "master" list of all financially meaningful entities and relationships--makes analysis of the financial resources of "hospitals" very difficult. The boundaries of the "entity" are not black and white. Under Generally Accepted Accounting Principles, a basic principle is the "economic entity assumption," which states that economic events can be

identified with a particular unit of accountability. Obviously, accountability is harder to maintain when this assumption is not met.

Question 5: What was the nature of the $2.2 billion in capital spending over the period 1984-1992? What is the committed additional $500 million going into? Is all of this capital expenditure "needed"?

The bulk of capital expenditure has been to replace and renovate inpatient capacity. However, inpatient utilization trends are downward both nationally and in Massachusetts.

Most of the certificate-of-need (CON)-approved projects between 1984-1992 were for inpatient facilities. Most were not to add beds, but rather to renovate, update, and provide new buildings. **Figure 6** shows the trends in operating beds over the period 1984-1991. Only four hospitals added a few beds; most hospitals downsized slightly.

The accounting age of plant (accumulated depreciation/depreciation expense) measures in a very rough way the "age" of plant. Since it combines equipment (average accounting lives of 3-7 years) with buildings (average accounting lives of 20-30 years), it can be affected by a number of factors other than "oldness" such as the mix of building and equipment, the degree to which capital asset ledgers are updated, and the specific policies regarding equipment age employed by the hospital. Also, it does not include leased buildings and

equipment, which can be a significant share of hospital capital capacity. In any case, the accounting age of the Boston hospitals is shown in **Figure 7**; the mean age of plant is below the regional mean throughout the period of analysis. It is roughly at the national mean; this suggests a very favorable plant age for Boston. The lower two tables show how each hospital's age compares to the Boston mean age. The left table shows the largest hospitals, all of which are below the Boston mean, and are therefore quite "young." The right table shows the smaller hospitals; BCH, Faulkner, and Carney are well above the mean age; while the others are at or below it.

Approved projects and the related estimated capital expenditures (including financing costs) are summarized below, in chronological order of their CON approval dates. The dollars approved may not be what was finally spent; it was not possible to match capital expenditures to specific projects from the audited financial statement information.

Hospital	Approval Date	$ Mil	Nature
Childrens Hospital	3/84	$87 M	new inpatient pediatric facility
Mass General	9/86	$190M*	new inpatient facility, 2 phases
Boston City Hospital	11/86	$170M	new inpatient facility
St Margarets/St Eliz	11/90	$33M	new obstetrics facility
New Eng Deaconess	12/90	$100M	new inpatient facility
Beth Israel	2/91	$97M	new inpatient facility
Brigham and Womens	3/91	$49M	new obstetrics facility
New Eng Med Ctr	5/91	$84M	new inpatient facility

		$41M	outpatient facility

*some of this may have been related to phase 2, see below

Projects currently underway per bond official statements, apart from CON information:

Beth Israel	underway	$156M	primarily ambulatory clinical center
	underway	$24M	research building
with Children's		$12M	ambulatory facility in Lexington
Mass General	underway	$99M	phase 2 of inpatient renovations; may commit $8 million to new obstetrics service
University	completed 1988	$77M	atrium pavilion, new inpatient facility

These projects do not include research buildings built over the last ten years by related and unrelated entities. For instance, a related entity of the Brigham constructed a $24 million building for research purposes, which it leases to the Brigham. A state authority, the Massachusetts Industrial Finance Authority, owns a $250 million building which it leases to the MGH, primarily for research. Children's added 170,000 square feet to its Enders Laboratory for Pediatric Research, completed in 1990. This is not a complete list of all spending for research facilities.

Clearly, the bulk of capital expenditures by the hospital entities over the last 9 years was for modernizing inpatient facilities. Within that category, two hospitals (NMC and MGH) are adding obstetrics facilities, while four others (BWH, ELZ, BCH, and BI) have spent millions

on modernizing their obstetrics facilities.

Capital costs (depreciation and interest) have meanwhile grown far faster than total operating expenses (see **Figure 8**). In 1986, capital costs were $75 of the $965 average daily cost of these twelve hospitals, or 7.8% of the per diem cost. By 1991, capital costs had risen to $131 of the $1409/day average cost, or 9.2% of the per diem cost. Excluding operating leases, which add another 1.9% to 1992 capital costs, capital costs have nearly doubled as a percent of operating costs since 1984. In terms of the components of capital costs, depreciation grew at an average annual rate of close to 50% per year and interest expense grew at an average annual rate of 16% per year. Total operating expense (excluding bad debt expense) rose at an average annual rate of 13% between 1984-1992.

However, demand for inpatient services, and for obstetric services, is flat or declining. The emphasis on investment in inpatient services conflicts with the environment of declining inpatient utilization trends of hospitals in Boston and statewide. For the 12 Boston hospitals, admissions trends have been essentially flat since 1990, while patient days declined 11.6% between 1990-1992 (see **Figure 9**). Statewide, 1991 admissions declined 3.5% from 1990; 1991 medical-surgical admissions were down 11.7% from 1988. Total patient days in the state have declined steadily since 1988; 1991 days were 8.7% below 1990 days.

Births are also declining (see **Figure 10**). As stated in the Beth Israel's 1992 official statement, "the declining birthrate led to a city-wide drop in obstetrical admissions, and

based on demographic information supplied by the Massachusetts Department of Public Health, it is expected that the birth rate in the Hospital's primary service area will continue to decline through the year 2000." They also note the opening of NMC's new obstetrical service, as well as the re-opening and/or expansion of obstetrical services by MGH and St. Elizabeth's. One of the Beth Israel's responses to this challenge was to recruit three new obstetricians who opened a private practice in the Chestnut Hill section of Newton in 1991. Another Beth Israel move was to build and open a new Neonatal Intensive Care Unit in 1992.

Declining inpatient trends are replicated nationally, where admission rates per 1000 population have dropped from 165.5 in 1980 to 124.9 in 1990.[5] Days per 1000 population have dropped 31% between 1980 and 1990.

One argument put forth to justify the high level of capital invested in inpatient facilities and equipment is the "forced by state policy" argument. Here, blame is laid at the doorstep of state policymakers who have made hospital payments increasingly volume-driven. In a period of excess capacity, hospitals must fight to attract volume and revenues away from each other. Hence, they try to outdo each other in having the most updated equipment and facilities. The flaw in blaming the state is that the hospitals themselves, particularly the large Boston teaching hospitals, played an influential role in forming state payment policy.

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[5]Source: Hospital Statistics, American Hospital Association; cited in Annual Health Care Information Book, Maine Hospital Association, 1991 Edition.

Massachusetts hospital costs are among the highest in the nation. Given these inpatient utilization trends, investing close to $1 billion for the replacement and renovation of inpatient capacity, and the addition of significant sums of debt to do so, seems hard to justify strategically and financially.

Question 6: How will hospitals keep their beds full and/or pay off their long term debt?

It is not clear that all of Boston's hospitals will survive in the next decade. Some argue that they are providing specialized services that the suburban community hospitals do not provide, but this argument is weakened by the fact that a large proportion of what Boston's hospitals do are simple "bread and butter" procedures. Two thirds of these patients are from the suburbs. Increased use of managed care might re-direct these patients to lower cost, suburban hospitals.

It is possible that not all hospitals in Boston will survive the next decade, with its anticipated emphasis on prevention, ambulatory services, and lower costs. One possibility is that these hospitals are so different from all other hospitals in the state, in terms of the tertiary nature of their patients, that they will maintain occupancy throughout the decade. However, a closer look at their inpatient specialty mix in 1991 suggests that a large proportion of what the Boston hospitals do to keep their beds full could have been done in a community hospital outside of Boston. Two-thirds of patients in Boston hospitals are not Boston residents, and a lot of them are coming into the city for non-tertiary type services.

A comparison of the specialty mix of services provided suggests that the inpatient mix of Boston hospitals is not all that different from the specialty mix of hospitals statewide. While some tertiary referral-type specialties do provide a greater share of revenues to Boston hospitals than to hospitals statewide, most of the revenues are generated in "bread and butter" specialties common to all hospitals, community and major teaching alike.

Table 4 shows the distribution of inpatient dollars by clinical specialty, in terms of charges or gross patient revenues generated. Over 50% of total Boston hospital inpatient dollars are generated by 4 of the 26 clinical subspecialties: general surgery (19%), thoracic surgery (13%), orthopedics (10%) and cardiology (10%). While thoracic surgery may be considered largely "tertiary referral" type business, general surgery, orthopedics, and cardiology represent the "bread and butter" of community hospitals. Statewide, general surgery represents 21% of all gross revenues, cardiology almost 22%, and orthopedics, 10%.

Another approach to assess the degree to which Boston hospitals provide tertiary vs. community-hospital services is to review the DRG mix within one of the "non-tertiary" subspecialties to see what proportion of the cases are clearly tertiary or non-tertiary. This was tried with the General Surgery subspecialty, the largest specialty in terms of patient revenues. While it was difficult to identify the cases that were truly tertiary, it was possible to get a rough estimate of the proportion of cases that were very unlikely to be tertiary-referral in nature. The results, summarized below, indicate that a minimum of 20% of the general surgery cases were definitely not tertiary-referral in nature.

Breakdown of General Surgery Cases:

Ninety percent of the cases in general surgery fell into five major diagnostic categories (MDC): digestive system (33%); skin, subcutaneous, and breast (25%); hepato-biliary and pancreas (15%), injuries and poisonings (10%), and endocrine/metabolic/nutritional (7%). Each MDC's general surgery DRGs were reviewed for their "tertiary" nature; short LOS (three days and under) was one guideline, as well as the statewide volume of the procedure (using 1988 MaHDC reports). A number of nontertiary conditions were identified to give a rough estimate of what proportion of General Surgery could be considered definitely not tertiary.

Thus for the digestive system MDC, we counted the frequency of uncomplicated hernia and inguinal/hernia repairs done in the twelve Boston hospitals. These represented 25% of all procedures done in the digestive system MDC. For the skin MDC, we tracked breast biopsies for nonmalignancies, pilonidal cysts and other perianal procedures, and other skin, subcutaneous, and breast procedures with ALOS less than or equal to 3 days. These collectively represented 20% of all procedures in the skin/subcutaneous/breast MDC. Uncomplicated gall bladder removals represented 35% of all hepato-biliary and pancreatic MDC procedures done in the twelve Boston hospitals. Two-thirds of the patients receiving these procedures in Boston hospitals in 1991 were not residents of Boston.

These procedures represent a significant share of the general surgery specialty, and suggest that quite a bit of what the Boston hospitals do could have been done in a community

hospital.

In thinking about the implications of this, at least two observations can be made. One is that the Boston hospitals' estimates of "need" for their inpatient capacity includes a considerable amount of care that could be taken away from them by managed care contracts that allowed only tertiary services to be done in Boston's tertiary hospitals. Thus in the future, along with all of the added financial risk of high debt levels and new inpatient facilities, the Boston hospitals may be at a particularly high risk of losing a chunk of their bread and butter business to community hospitals under managed care.

The second observation is a related one: in order to protect their inpatient market share, the Boston hospitals are likely to become even more aggressive at taking bread and butter as well as tertiary referral patients away from their community hospital competitors, to the extent that such patients are not constrained by managed care. One wonders how well the various cooperative agreements between the major Boston teaching hospitals and community hospitals will work out if managed care puts intense pressures upon the Boston hospitals to maintain inpatient volume. All of this certainly suggests that there is a need to look at inpatient capacity throughout the system, and not just in the city of Boston, to get a feeling for what may come about in the not too distant future. It also suggests that pouring hundreds of millions more dollars into inpatient renovations and replacements will exacerbate the problem.

Question 7: What role does philanthropic giving play in producing all of these buildings? Does it lower the cost of care to patients? Does philanthropy enable the weaker hospitals to maintain buildings and services that they might otherwise not be able to provide?

The Boston hospitals which have benefitted the most from philanthropy are those which were financially strongest to begin with. Whether a hospital uses philanthropy or borrows money to finance capital construction, the patients still pay for the building and the equipment.

When philanthropy is used to build a patient care or a research building, it is used as a "financing" vehicle. That is, it helps to pay the construction costs of the facility. Then, when the building is put to its intended use, capital charges (depreciation, and interest on borrowed financings) are part of research overhead rates as well as patient charges. In other words, the hospital seeks to recover its full capital investment from patients and research grants, regardless of whether philanthropy or debt was used to finance the building. Thus, philanthropy reduces interest costs, but it does not reduce charges to patients for their use of buildings and equipment.

Philanthropic giving has played a major role in financing building projects for some of the hospitals, and an insignificant role for others. The distribution of philanthropic dollars for building projects does not support the notion that philanthropy is going to institutions that are

unable to provide a viable level of service or maintain competitive plant without it. A summary of what hospitals reported in their official statements in 1990-1992 gives some idea of the role played by hospital building fund drives. The MGH reportedly raised $175 million in its last round, 1987-1991. Its board has authorized another $160 million fund raising campaign, of which only $54 million is intended to be used for building purposes. Beth Israel has accumulated a total plant replacement fund balance of $21 million (market value), of which $6 million was raised between 1987-1991. As of 1992, they have announced a $55 million building fund drive. Children's raised $40 million in its 1986-1990 Building Fund Drive. New England Deaconess just hired away the MGH fund raiser to help it raise $35 million for its new buildings. Between 1987-1991, the Deaconess raised $9.7 million for plant replacement and expansion. These are not among the financially weaker hospitals, although BI and NED have been ambitious in their capital spending relative to both their financial position and their market share.

The role of philanthropy in Boston has been to provide even more strength to already financially advantaged hospitals. It contributes to their ability to make greater capital expenditures than their competitors.

Question 8: Are the financial resources described here--cash from operating activities, philanthropy, discretionary cash balances, and capital assets-- shared equally among the twelve Boston hospitals, relative to their size or patient output?

There are vast differences in financial health among the 12 Boston hospitals. Table 5 summarizes findings regarding the relative financial resources of the 12 Boston hospitals. It suggests three "groups" of hospitals. Group 1 includes the three largest, strongest hospitals on the dimensions listed above. While Children's is not quite on the same scale as BWH and MGH from its operating cash flow and capital expenditures, its consolidated cash balances are clearly superior to all other hospitals in Boston. The cash strength reflects Children's enviable philanthropic appeal and its ability to realize high returns on its investments.

Group 2 represents five hospitals with cash flow from operating activities as well as cash balances of between 25-50% that of Group 1 hospitals. However, they approach the level of capital spending of the group 1 hospitals. In order to do so, they have added significantly greater liabilities relative to their equity (see equity financing ratios; lower is less favorable). With their relatively high debt service requirements, Group 2 hospitals are particularly vulnerable to the financial risks of a rapid reduction in inpatient volume.

Group 3 represents four hospitals with cash flow from operating activities between 25-50% of that of Group 2 hospitals, and cash balances of less than half the Group 2 hospitals. Baptist is financially the strongest of the four, with its young plant age and relatively lower reliance upon debt. The remaining three suffer from very old plant or very high debt levels or both. Except for BCH, Group 3 hospitals have experienced the highest reductions in inpatient volume of the twelve hospitals, averaging declines of over 6% per year since 1988.

Size or level of output obviously plays a major role in establishing relative financial resources of these twelve hospitals. A slightly different impression emerges when "output" is adjusted for, however crudely. **Table 6** describes each hospital's share of the cash flow from (1) operating activities, (2) capital expenditures, and (3) 1992 cash balances, relative to their share of adjusted inpatient days, adjusted for outpatient volume. Due to data limits, only 1991 inpatient days were used as output measures, adjusted for outpatient activity by the formula Total Gross Patient Revenue/Inpatient revenue * inpatient days. One assumption is that 1991 shares of patient output reflect hospital shares throughout the nine year period.

Table 6 shows that MGH, with the highest share of adjusted output, has a roughly proportionate share of the three financial resources described. However BWH, with 15.3% of adjusted patient days, has a disproportionately high share of cash from operating activities, 1.43 times its share of patient output. BI has a disproportionately high share of capital investment, 1.59 times its share of patient output. NMC also has a relatively high share of cash from operating activities and plant expenditures. BUMC has a disproportionately high share of cash balances, 1.36 times its patient output share. However Children's share of all three financial resources is well beyond its share of patient output: it captured 1.9 times its patient output share in cash from operating activities, 1.7 times its patient output share in plant expenditures, and 3.75 times its patient output share in 1992 cash balances.

At the low end of proportionate share is BCH, which fails to capture its share of cash from operating activities and cash balances. Only by taking on a very large debt burden is it able

to add plant at a level more closely related to its share of patient output in the city. Carney is not far behind BCH, with relatively low shares of all three measures of financial resources. Faulkner, Carney, and St. Elizabeth's have disproportionately low shares of expenditures on property, plant and equipment. The hospitals with the least absolute resources are the same as those with the least resources relative to their patient care output.

Question 9: Are the hospitals with the strongest financial position also the hospitals with the greatest commitment to the local community (Boston), to the uninsured, and to minorities?

Generally, the weakest hospitals financially are the most committed to the local Boston community. This could present a problem in the near future as battles over filling beds and meeting debt service intensify.

We looked at three types of patient characteristics: payer status (particularly the uninsured: free care and self-pay designations), residence (Boston/nonBoston), and minority (African-American and Hispanic) status.

These three were chosen as one way to describe patient service commitments of the hospitals to these "communities" of public health interest. There are other important indicators of "community benefit" this analysis will not address, such as community outreach and social services. Given time and data constraints, only patient service commitments could be

analyzed in this effort. The hospitals are expected to articulate their version of community benefits as part of an ongoing effort by the Massachusetts Hospital Association.

In justification of this approach, however, the bulk of dollars spent by all hospitals are for patient services. This study reviews the financial resources amassed by these hospitals in light of their patient service commitment to the local community. Thus, this analysis addresses only the patient service benefits to Boston, to indigents, to minorities, of these hospitals, which represent the local hospital resources used by 90% of Boston residents. Boston residents pay higher property taxes as well as higher health care premiums by virtue of having these institutions in their community. This analysis quantifies the relative commitment of each hospital to the local population, as well as to key other populations (indigent and minority, for Boston and non-Boston residents) that often represent special patient service needs.

We obtained the Massachusetts Health Data Consortium (MaHDC) patient origin data for the 12 Boston hospitals to get an overview of the patient characteristics of those served. The MaHDC data describes only inpatient characteristics. We requested outpatient characteristics of the hospitals directly, but most were unable to comply with our request. Information from the three that did have information on outpatient characteristics is included in the analysis.

Inpatient Services

All twelve hospitals provided some services to Boston residents, uninsured patients, and

minorities. **Table 7** describes each hospital's share of total discharges of each subpopulation, as a "raw" measure of commitment.

To adjust for the relative financial resources of the 12 hospitals, the share of each patient population was divided by the share of each hospital's cash from operating activities over the period 1984-1992, to come up with a measure of "relative commitment" to each of the three populations of interest (**Table 8**).

Uninsured Patients: According to the methodology used in **Table 8**, BCH has the strongest commitment to uninsured patients (the free care and self-pay payer classes), relative to its financial resources. It should be noted that this commitment has not been funded by the City of Boston over the last nine years. Rather, the hospital has provided the city with a cumulative net subsidy over that period. The free care pool and a special Medicaid rate were the primary sources of subsidy for BCH's uncompensated care up to now. As of 1991, BCH provided services to one-third of all uninsured patients discharged in the city.

Carney also shows a strong commitment to free care patients, relative to its financial resources. However Carney does not have a large share of financial resources.

The MGH shows the third highest relative commitment to providing services to uninsured patients, at a rate roughly equal to their share of financial resources. In absolute terms, the MGH provided almost 14% of the uninsured discharges in 1991.

The lowest relative commitment to uninsured inpatients was by New England Deaconess, Faulkner, and Children's. Each hospital's relative share of free care and self-pay patients was less than or equal to half of its share of cash from operating activities. While Children's "absolute" commitment was 5.8% of total uninsured patients treated in 1991, this is quite low relative to its share of total financial resources.

Service to Boston Residents: In terms of relative commitment to Boston residents, the hospitals that served Boston residents in proportion to their share of financial resources (or more) were BCH, Carney, Faulkner and Beth Israel. Three of them (BCH, Carney, Faulkner) draw over half their patients from Boston; Beth Israel draws 35% of its patients from Boston.

These four provided 38% of all inpatient services to Boston residents. Three other hospitals provide another 30% all inpatient services to Boston residents: BWH provides the highest volume in terms of discharges; MGH and St. Elizabeth's also provides a significant share of services to Boston residents. The difference between these three and the first three is in their commitment to Boston residents relative to their financial resources.

The least committed to Boston residents are Childrens and New England Deaconess. Childrens' share of Boston residents is just 34% of its share of financial resources, defined as the 9-year cumulative cash flow from operating activities. Another way of looking at this is that only 22% of Childrens' patients are Boston residents; less than 15% of Deaconess'

patients are Boston residents. Thus these two hospitals have devoted most of their inpatient resources to patients from outside of Boston.

Minority Patients: These figures are supposed to include African-American and Hispanic patients as minorities. There is some evidence that not all hospitals code patient race accurately. For instance, we eliminated Faulkner's minority discharge figures because they indicated that over 90% of Faulkner's patients were minorities. The following findings should be considered more likely to represent reporting errors by the hospitals than the Boston and uninsured figures presented above.

The highest relative commitments toward minority patients came from BCH, the Brigham, Carney, University, and Beth Israel, all of which served a share of the minority population that was equal to or greater than their share of financial resources.

On the low end of relative commitment were New England Medical Center, New England Deaconess, and MGH.

Outpatient Services

Outpatient services constitute roughly 20% of the total patient revenues of most of the Boston hospitals. **Figure 11** describes the trends in outpatient share between 1986 and 1991. For six of the 11 hospitals for which we have trends, outpatient share of revenues did not increase significantly, indicating that growth in inpatient revenues kept up with growth in

outpatient revenues. For the other five, growth in outpatient revenues exceeded growth in inpatient revenues. The five that increased the proportion of outpatient/total revenues had relatively low outpatient shares of total revenue in 1986 compared to the other six. Thus 1986-1991 appears to be a period of "catch-up" for them.

For the three hospitals providing outpatient characteristics, the proportion of visits provided to indigents and Boston residents is higher than the proportions for inpatient discharges. **Table 9** summarizes the available outpatient and inpatient patient characteristics of those three hospitals. It seems particularly important, as one tries to quantify relative commitment to the local community, to develop better outpatient patient characteristic information. Meanwhile one might reasonably assume that outpatient share of revenue is one rough measure of relative commitment to Boston residents and indigent care. The higher the outpatient share of total revenue, the stronger the commitment.

The three hospitals with the lowest share of revenues from outpatient services are New England Deaconess, New England Baptist, and University Hospital. As the inpatient discussion indicated, New England Deaconess and New England Baptist had low commitments to inpatient service to Boston residents, to free care/self-pay patients, and to minority patients, relative to their financial resources. These two hospitals appear to be primarily committed to a non-Boston, insured, non-minority patient population.

BCH's commitment to outpatient services is roughly twice as large as the other hospitals'

commitment, measured in terms of outpatient share of total revenues. It also has the highest inpatient share, relative to its resources, of Boston residents, free and self-pay patients, and minority patients. BCH is clearly the hospital most committed to serving Boston and its more vulnerable sub-populations. **Figure 12** shows that its commitment to the uninsured inpatient has grown over the period 1986-1991, while **Figure 13** indicates that its privately-insured patient base has gone from 20% of discharges to only 10% of total inpatients.

Question 10: What specialties are disproportionately used by the uninsured?

The uninsured utilize certain specialties more than their numbers would otherwise justify. "Overuse" of these particular specialties appears to be related to lack of primary care.

A final question we asked was what services seem to be most heavily used by the uninsured patients. The reason for asking is to identify those services most at risk of being withdrawn under a financial crisis should it occur. Thus, we compared the overall frequency of uninsured cases to their frequency by specialty, to get a sense of what services the uninsured use disproportionately.

Figure 14 describes our findings. Some of the specialties with disproportionately high uninsured frequency could be characterized as those associated with inadequate primary care. The uninsured were 7.6% of all patients served in Boston hospitals in 1990; they were

nearly 20% of inpatient dentistry patients, close to 11% of dermatology, general medicine, and ophthalmology patients, and 9.5% of rheumatology, gastroenterology, and pulmonary patients.

The other high frequency specialties appear to be related to trauma: the uninsured represented close to 11% of neurosurgery patients, and close to 10% of general surgery patients.

A study by the Rate Setting Commission found related results.[6] In their analysis of the patient origin information organized by the Codman Research Group, they made the following conclusions about patient care in Suffolk County, of which Boston hospitals are a subset:

- Suffolk County far outpaces other regions in terms of hospital utilization;
- Suffolk County may have a problem with access to adequate primary care services;
- In the low income populations, the admissions that vary the most above the state average are predominantly ambulatory-care sensitive admissions and HIV-related conditions;
- The low income populations are below state average for referral-sensitive admissions; and
- For the high income populations, referral-sensitive admissions are above the state average.

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[6]Massachusetts Rate Setting Commission. Health Care Costs in Massachusetts. December, 1992.

CONCLUSIONS

1. Hospitals are community-supported institutions, through tax subsidies and the health care premium structure. However, they accept limited public input into how to spend their financial resources. Hospital resource decisions reflect institutional needs. These can at times seem at cross purposes to "community" or system-wide needs. As two prominent observers of the health care system recently noted, "individual acts of local purpose can add up to systemic nonsense."[7]

Viewing the community's health needs from the point of view of constructing a rational system of care (as opposed to the individual hospital's view), excessive capital investment and high discretionary cash balances may be interpreted as inappropriate, particularly if hospital rates are high and affecting the ability of the community to afford health insurance. Employers who face rising premiums or the possibility of mandated health insurance see every new job, capital investment, or dollar of cash reserves going to the health care industry as one less job, capital investment, or dollar of retained earnings going to their industry. Neighborhood health centers may see each square foot of a new atrium or duplicative obstetrical suite as one less square foot of primary care capability. Poor communities lacking access to primary care doctors may see a new doctor's office building in Chestnut Hill or Lexington as one less opportunity to provide them with appropriate care. Although community needs are not centrally articulated, they are expressed in a fragmented chorus

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[7]Hiatt H and Berwick D. "Let's Replace Patchwork with a Partnership," Boston Sunday Globe, Nov.1, 1992.

throughout the Boston area. The system requires more than a simple accounting of each hospital's free care or local donations relative to its tax exempt benefits; the latter is only what the hospital determines to be its community contribution.

To advance the notion of a health system with community goals, it would be useful to have a health plan or public reference point describing what communities expect of major teaching hospitals, and to have a mechanism to assure that those expectations are financed and implemented.

2. Accountability of hospitals to the public is difficult to accomplish given the complexity of accounting practices and organizational structures flourishing in Boston. Because nonprofit hospital corporations lack specific investors who would be self-interested, hospitals lack sophisticated outside users of publicly available hospital financial information. Perhaps because so much of their revenue comes from or is affected by decisions of political agencies, the clarity and meaningfulness of publicly available hospital financial statements leave a lot to be desired. The "bottom line" of the hospital income statement is not particularly credible or useful in assessing the financial situation of a hospital. Balance sheets are nearly as hard to decipher meaningfully as are income statements. The ability to transfer assets to related affiliates or to report them under various "restricted" designations add to the frustration of outsiders trying to look in. In order to get a complete picture of a hospital's assets, it is often necessary to collect financial statements of several related entities; sometimes the only available financial information on related entities is from IRS filings

(Form 990's), which use IRS rules of accounting rather than generally accepted accounting principles. If public accountability is to be established and maintained, improved reporting practices are needed.

3. The Boston hospitals as a group garnered enormous financial resources over the last decade. These have been largely targeted to capital investments in inpatient care, where there is excess capacity now and in the foreseeable future. They have also accumulated substantial cash balances as "contingency funds," not required for current uses but maintained to help the strongest hospitals deal with the uncertain future. Philanthropy has largely benefitted the financially advantaged institutions, not all of which have a strong local commitment to Boston, to uninsureds, or to minority populations.

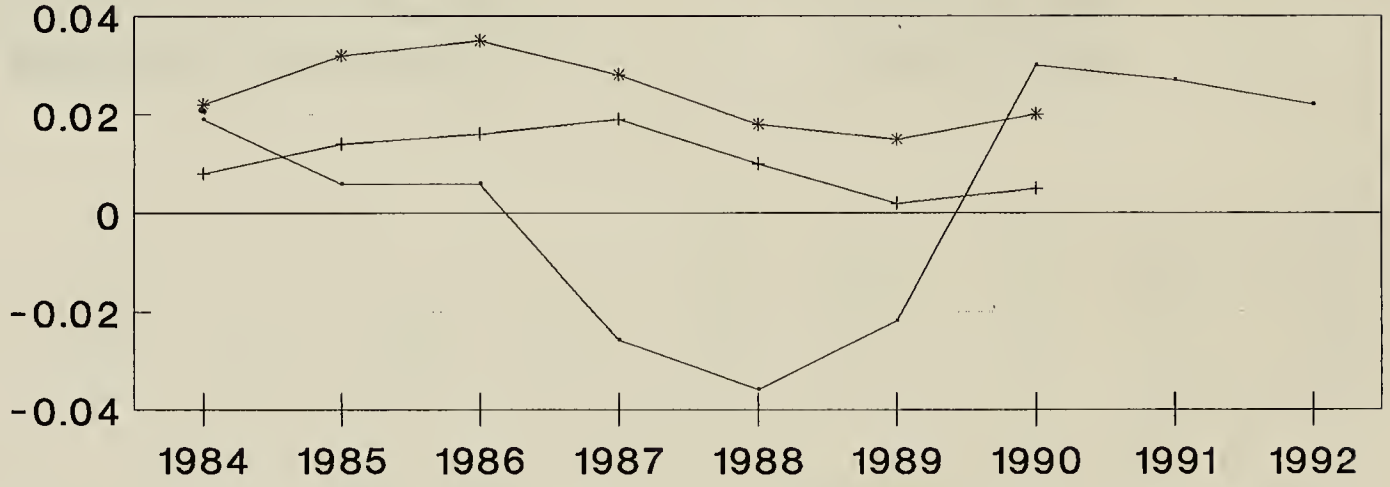
4. Those hospitals with the least financial resources are among the strongest in their local commitment to Boston and to the uninsured and minority populations. These hospitals are likely to face increasing competitive pressures, however, and their survival is most threatened by the excess capacity and financial strength of their Boston competitors. The potential loss of institutions whose primary mission is to the residents of Boston should be high on the list of public policy concerns in the city.

and Appendices

Figure 1

Mean Operating Margins

Boston, Northeast, National



	1984	1985	1986	1987	1988	1989	1990	1991	1992
Boston	0.019	0.006	0.006	-0.026	-0.036	-0.022	0.03	0.027	0.022
Northeast	0.008	0.014	0.016	0.019	0.01	0.002	0.005		
National	0.022	0.032	0.035	0.028	0.018	0.015	0.02		

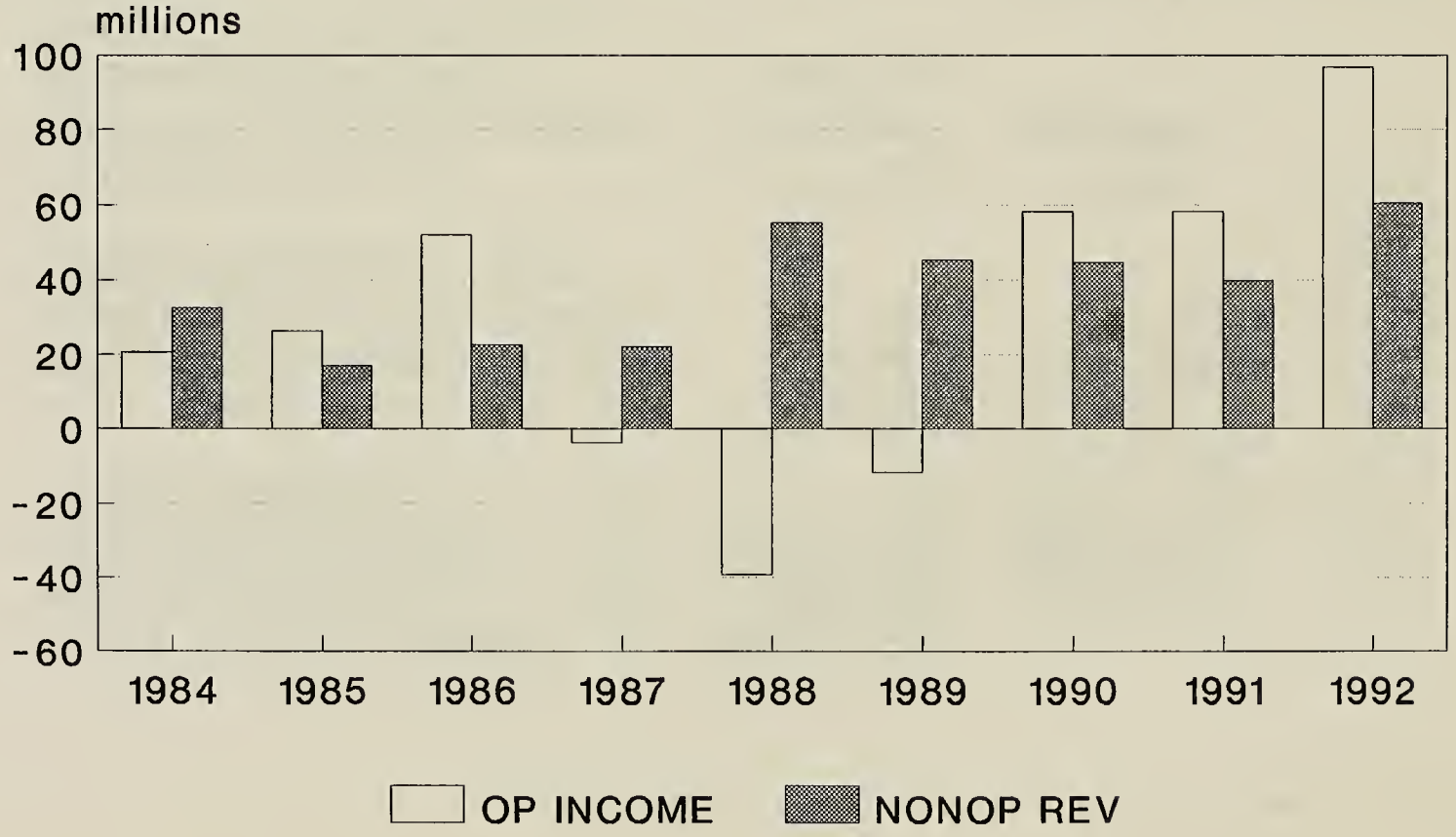
source of northeastern and natl: HFMA

Table 1

CUMULATIVE INCOME STATEMENT 1984-1992, 12 HOSPITALS

TOTAL OPERATING REVENUE	$19,996,927,000
TOTAL OPERATING EXPENSE	$19,738,724,000
OPERATING INCOME, 1984-1992	258,202,000
NONOP REVENUE, 1984-1992	340,123,000

Figure 2
Cumulative Operating Income and Non Operating Revenues



12 BOSTON HOSPITALS (STM AND STE MERGED)

Table 2

SOURCES OF CASH
12 BOSTON HOSPITALS, 1984-1992

SOURCE	$ 000	SUBGROUP TOTAL
OPERATING ACTIVITIES		
OPERATING INCOME	258,202	
NONCASH EXPENSE (REV)	1,126,842	1,590,099
WORKING CAPITAL*	205,055	(43%)
DONATION+INVEST. INC.		
NONOPERATING REVENUES	340,123	
RESTRICTED FUND TRANS	179,960	566,982
AFFIL TRANSACTIONS	46,899	(16%)
LONGTERM DEBT		
NET INCR LT DEBT	1,342,731	1,500,755
INCR OTHER LIAB	158,024	(41%)
TOTAL CASH PROVIDED	3,657,836	

EXCL AFFILIATE ACTIVITIES, INCL LT TPS

Figure 3-A

Annual Capital Expenditures
12 Hospitals in Boston

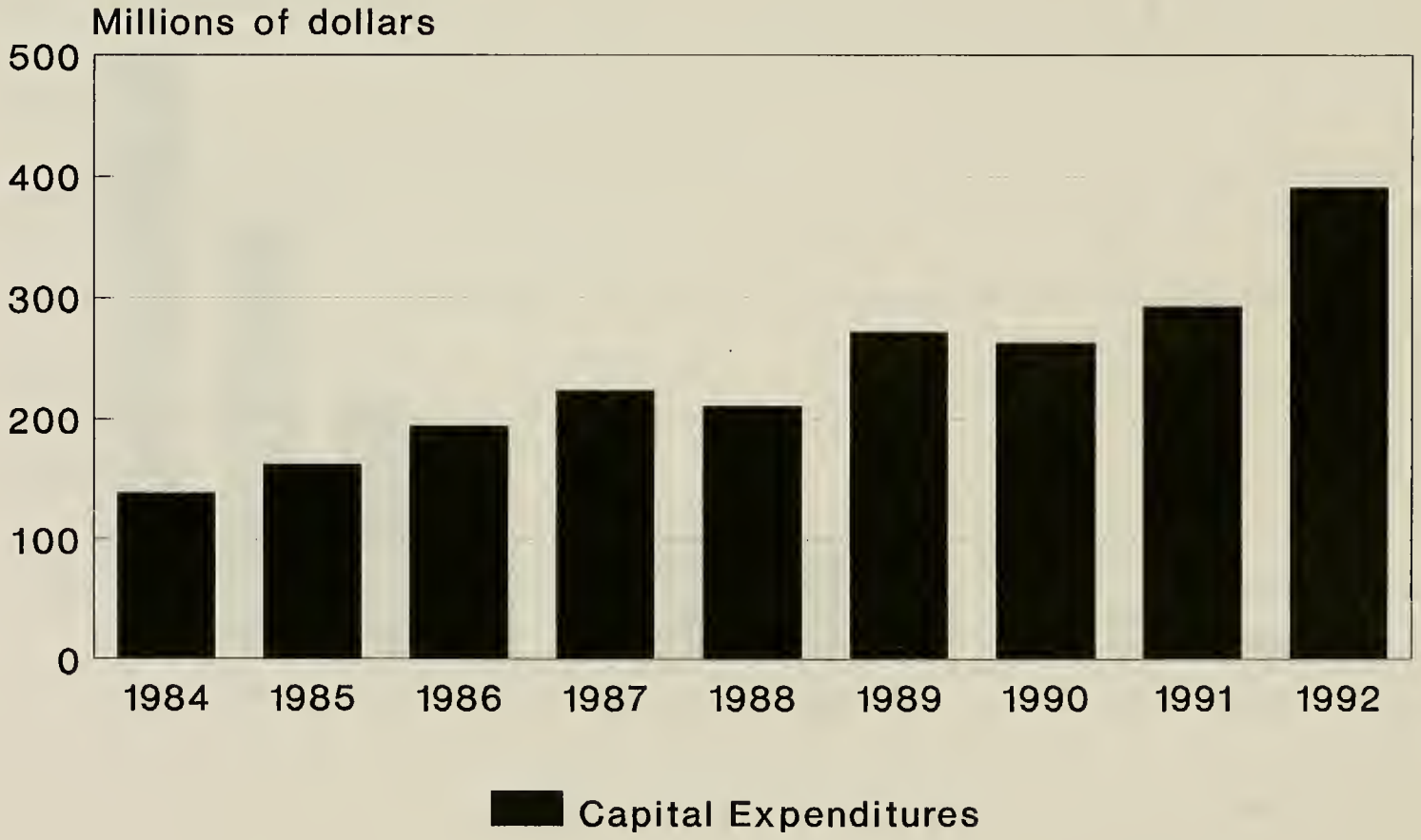
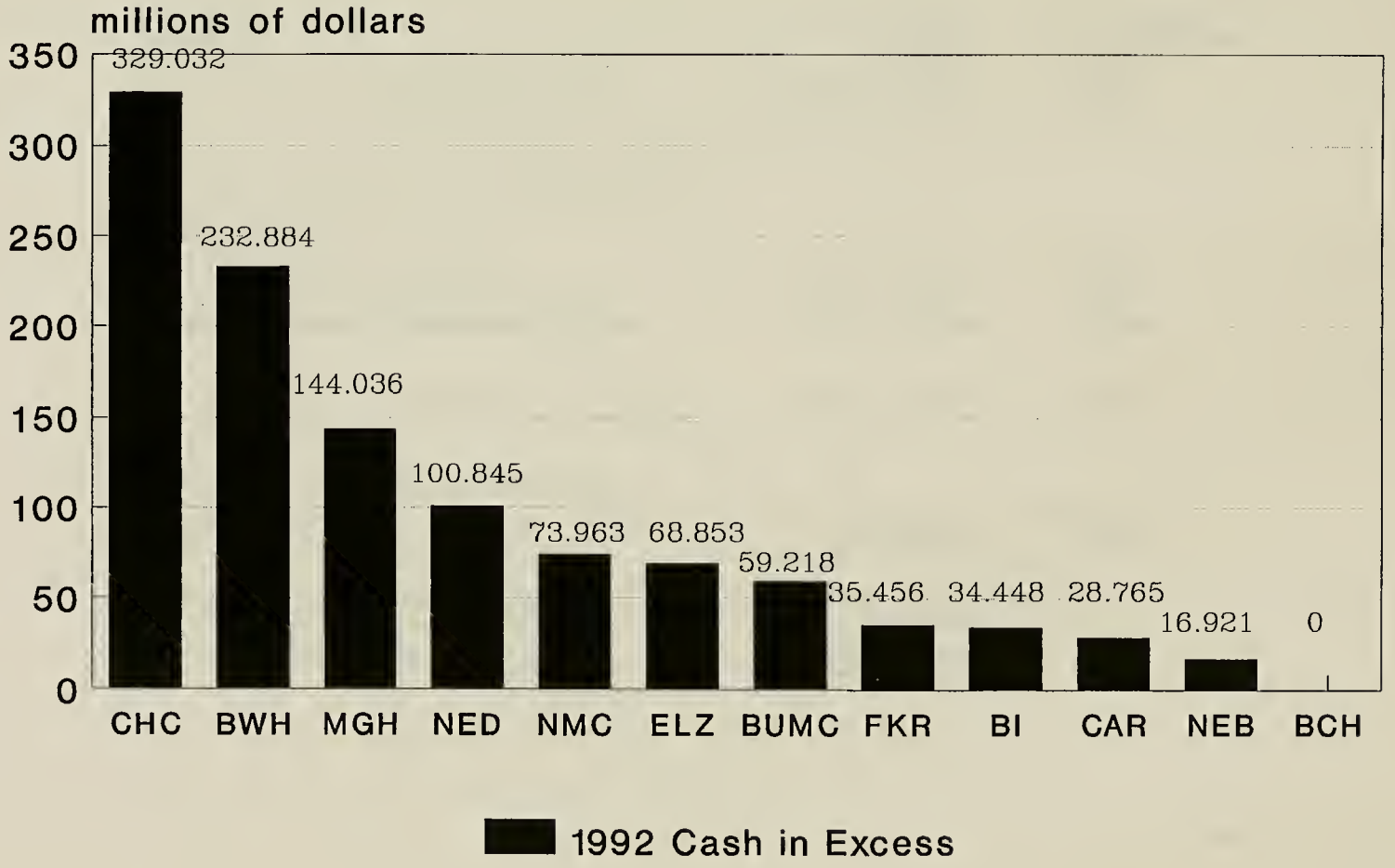


Figure 3-B
1992 Cash Balances in Excess of Industry Norm Including Affiliates



-board-des & WC cash balances only
-op expense less deprec, bad debt, and direct research expenses
-BWH, NED and NMC: includes 1991 cash balances from affiliates
-Industry norm = 20 days of operating expenses

Table 3

USES OF CASH 1984-1992
12 BOSTON TEACHING HOSPITALS

USES	$ 000	% TOTAL
PLANT & EQUIPMENT	2,205,662	60%
INVESTMENTS (STOCKS & BONDS):		
TRUSTEE-HELD	618,744	17%
BOARD-DESIGNATED	211,330	6%
WORKING CAPITAL CASH	556,188	15%
OTHER NONCURRENT ASSETS	54,303	1%
NOT RECONCILED	11,606	
TOTAL CASH USED	3,657,836	

cash out transactions only

Figure 4

FINANCIAL RESOURCES, 1991
12 BOSTON TEACHING HOSPITALS

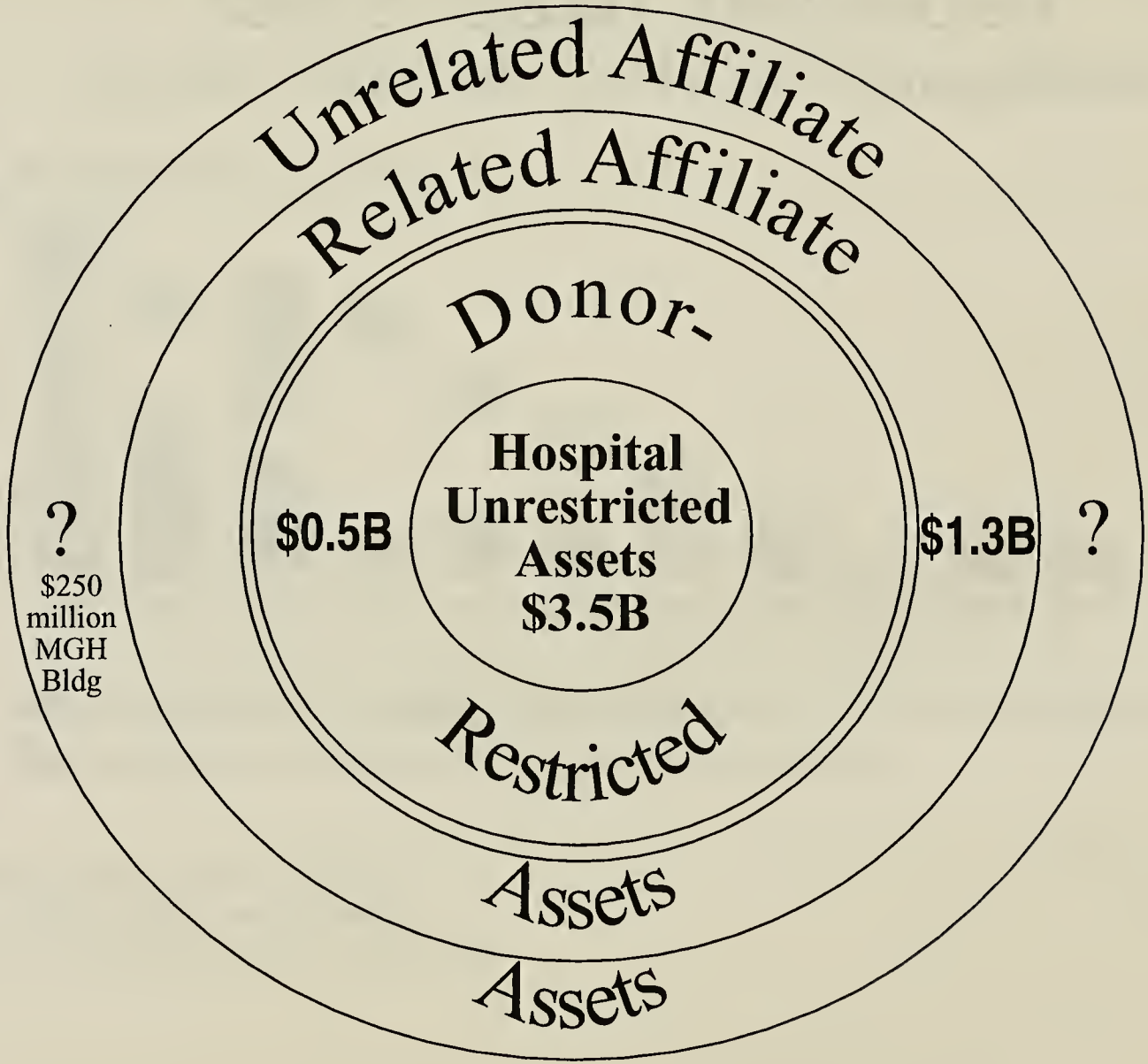
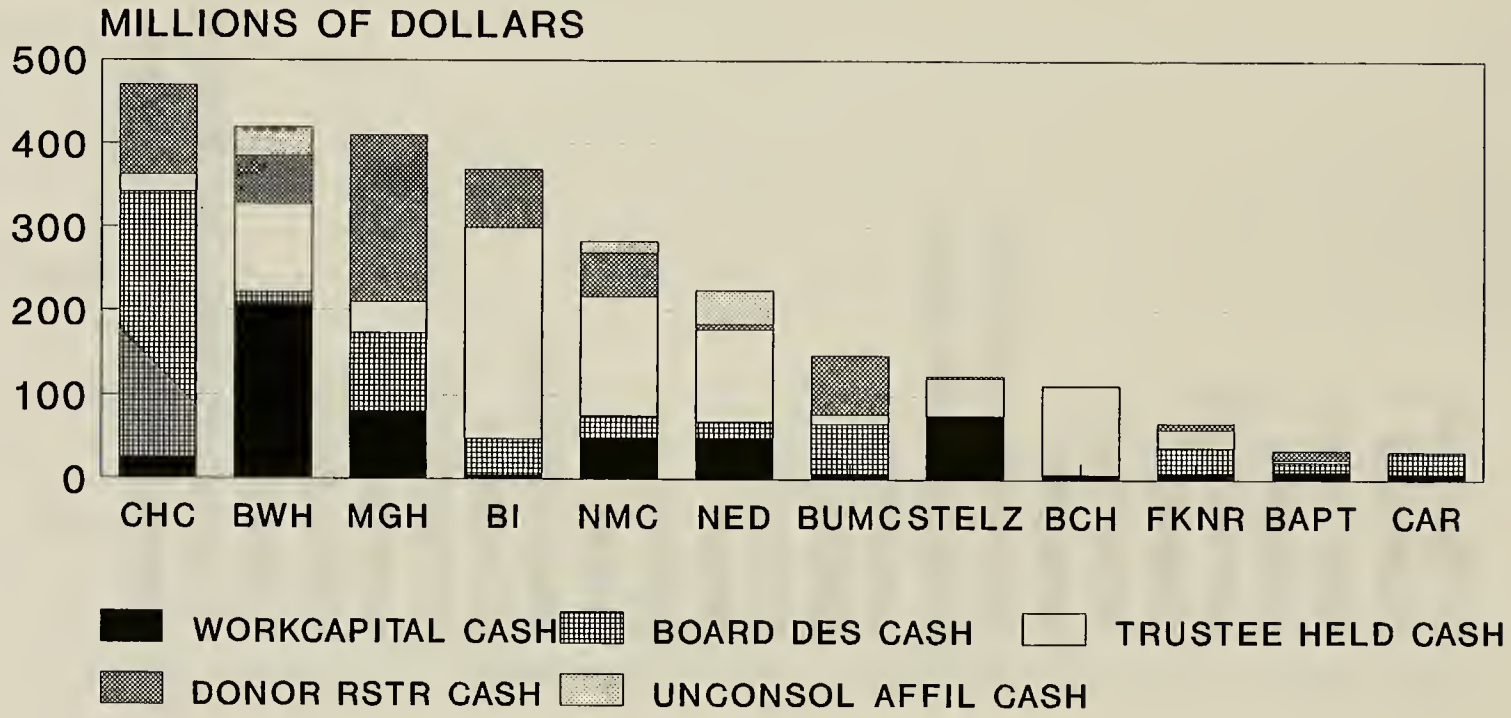


Figure 5

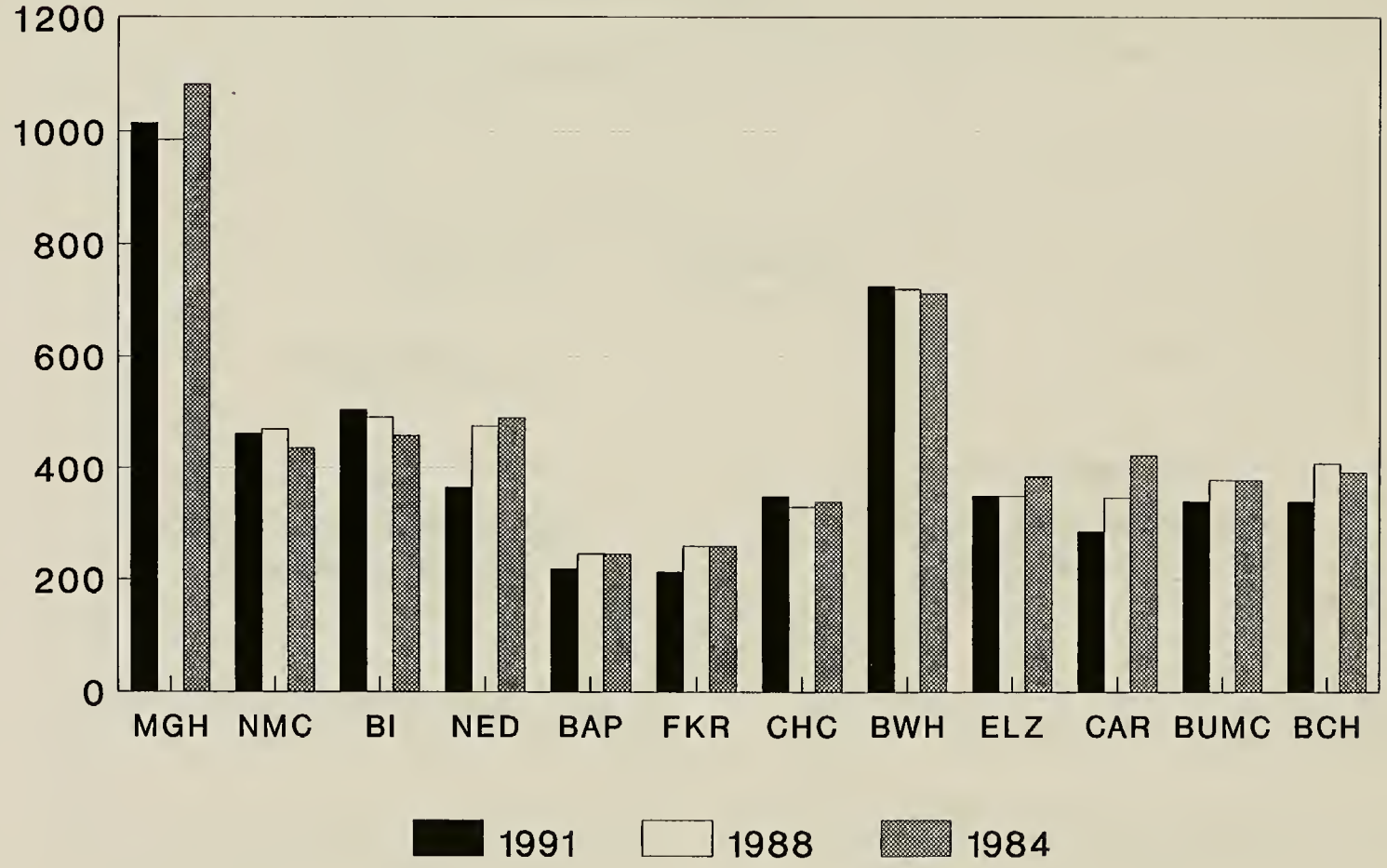
1992 Cash Balances

Boston Hospitals Affiliates Consolidated



UNCONSOLIDATED AFFIL CASH =
AMTS IN AFFILIATES 1991, WHERE
CONSOLIDATED 1992'S NOT AVAILABLE

Figure 6
OPERATING BEDS



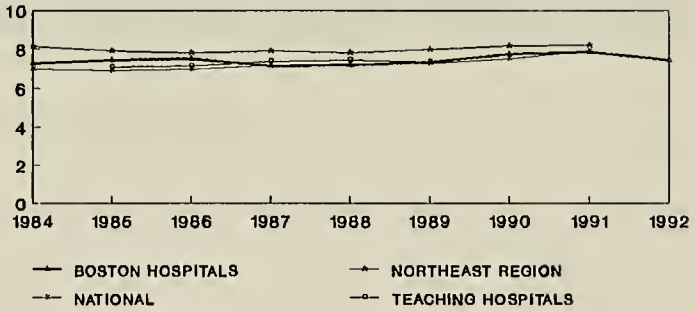
Source: AHA Guide

Figure 7

(1)

Mean Plant Age

Boston Hospitals

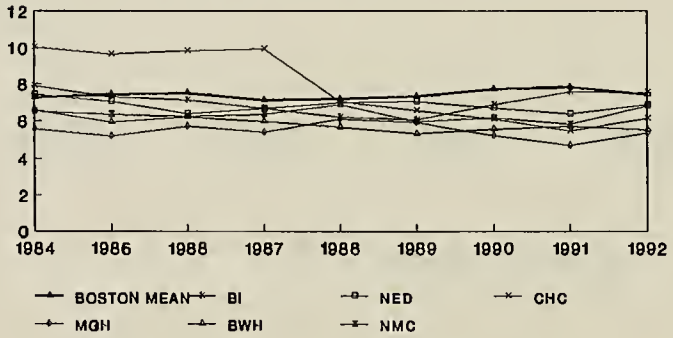


source for nonBoston:
HFMA Financial Report of the
Hospital Industry; Cleverly WO.

(2)

Plant Age Distribution

Large Boston Hospitals



(3)

Plant Age Distribution

Smaller Boston Hospitals

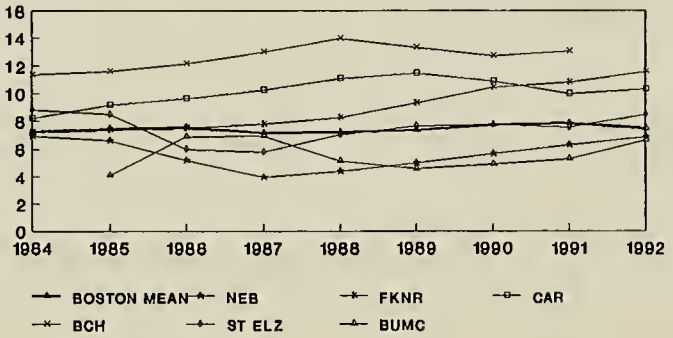
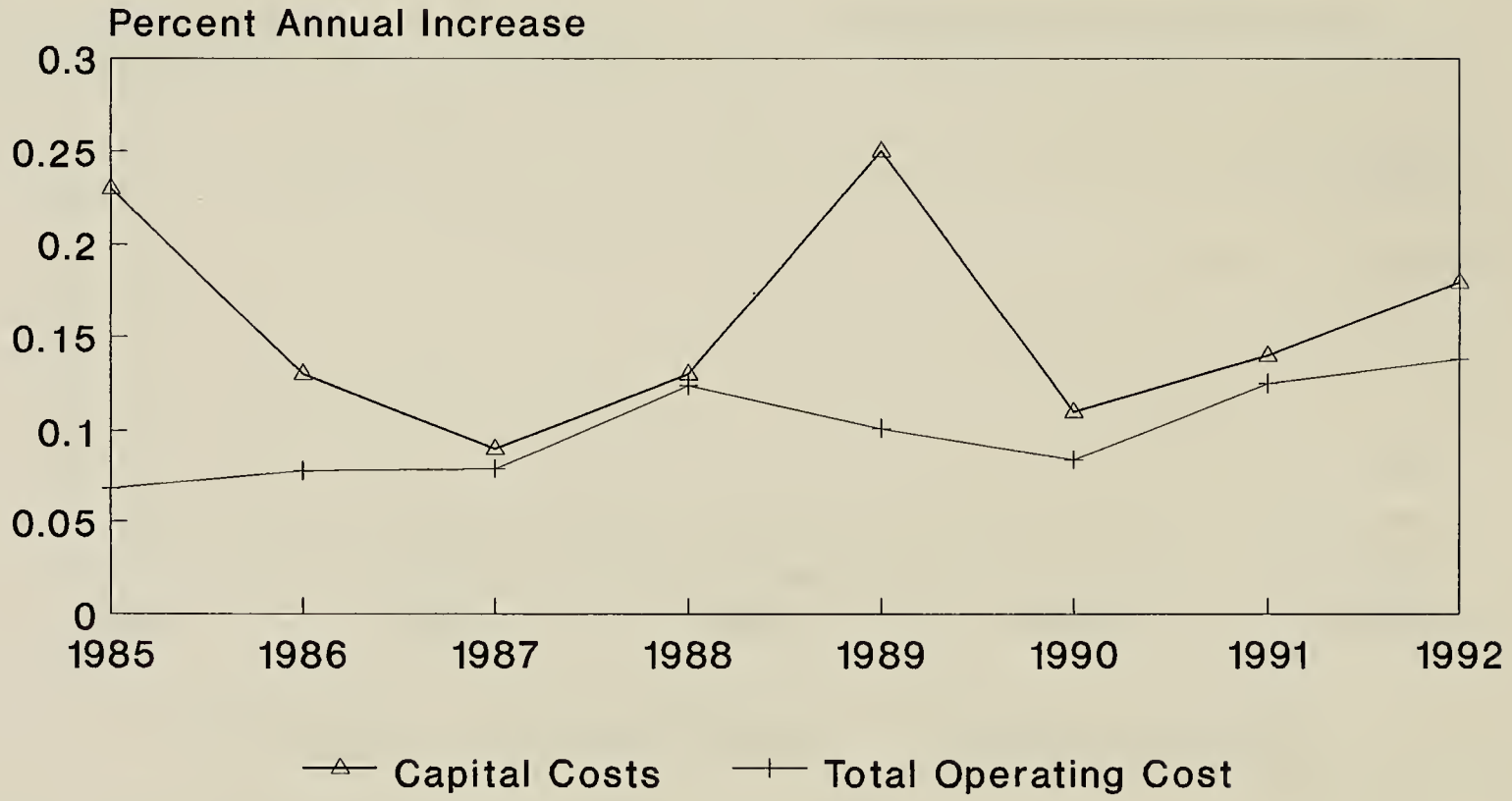


Figure 8

Annual Growth Rates

Capital Costs and Total Operating Costs

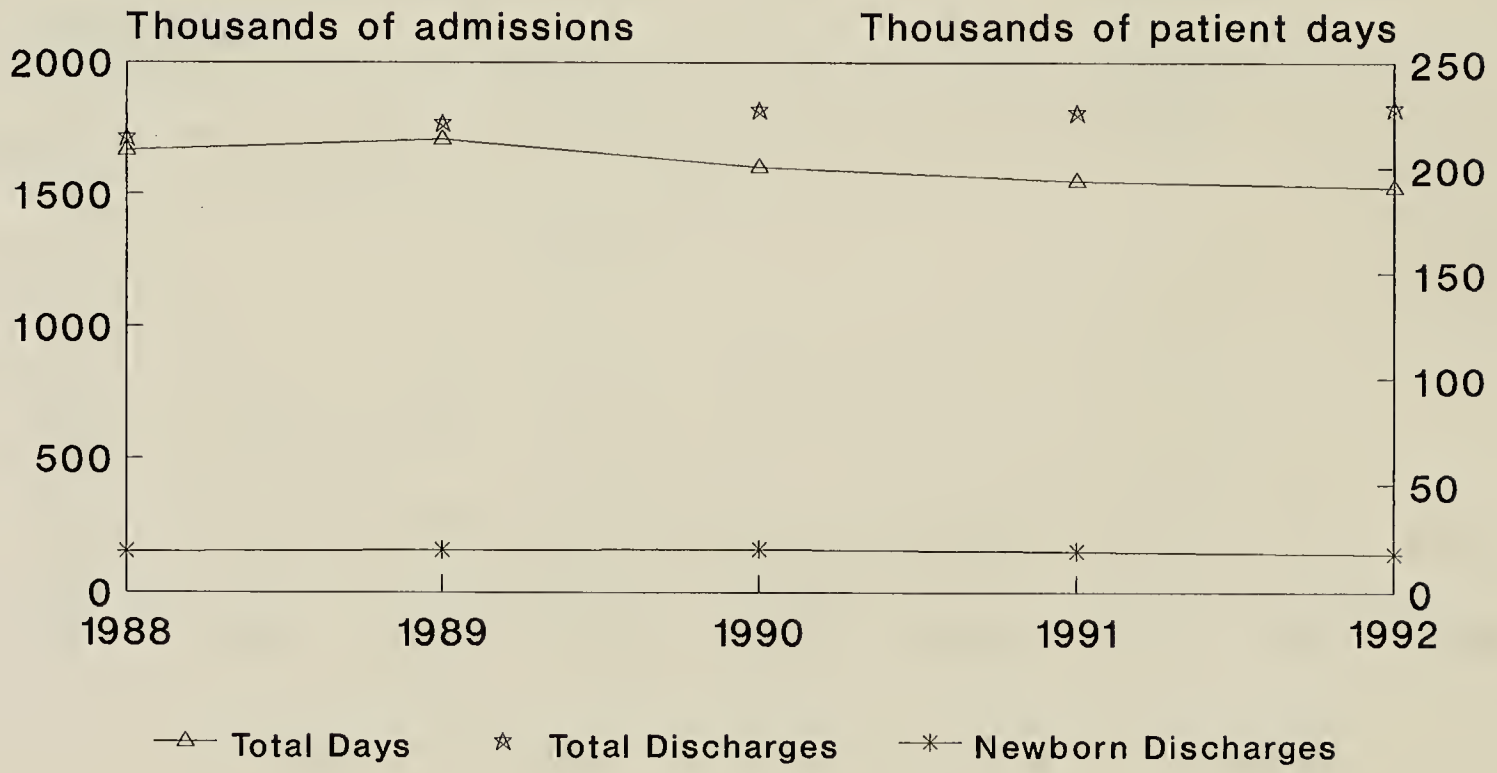


capital costs = depreciation & interest

Figure 9

Inpatient Utilization Trends

12 Boston Hospitals, 1984-1992

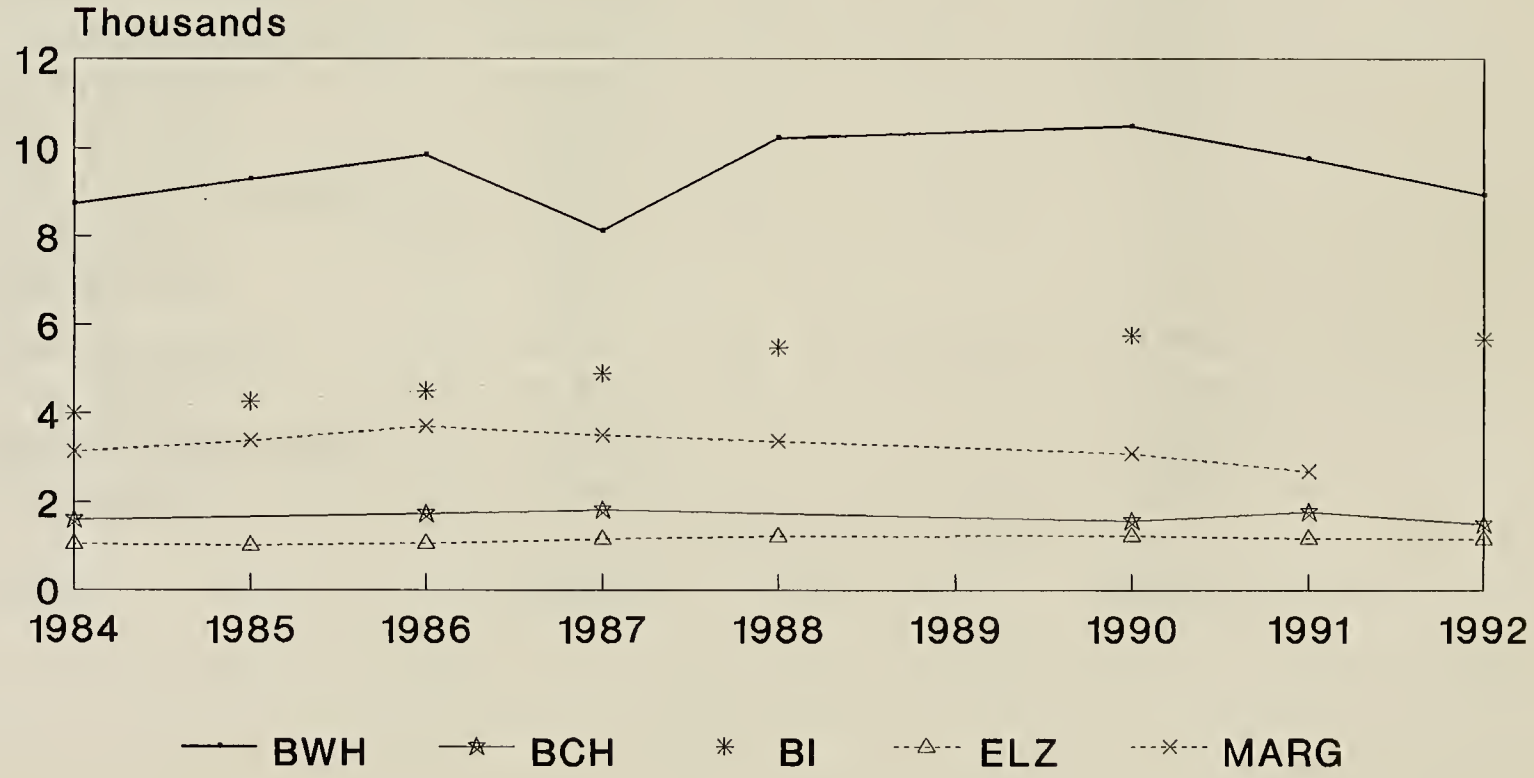


source: RSC 403; audited financials
excl St Margret

Figure 10

BIRTHS

Boston Hospitals



SOURCE: AHA GUIDE; 1992, HOSPITALS
St. Margrets closed in 1992

Table 4
Distribution of Charges by Specialty
State Average vs Boston Average

Clinical Specialty	% Statewide Charges	% Boston Charges
General Surgery	20.8%	18.9%
*Thoracic Surgery	6.5%	12.8%
Orthopedics	10.4%	10.3%
Cardiology	21.5%	9.9%
*Vascular Surgery	3.8%	4.5%
Pulmonary	7.4%	4.4%
Obstetrics	5.1%	4.3%
*Neonatology	2.9%	4.1%
*Urology	3.3%	4.4%
Gastroenterology	4.4%	3.3%
Oncology	3.3%	3.1%
Total	92.1%	82.6%

state average from 1988; Boston average from 1991
* Boston % > Statewide%

Table 5
Relative Financial Resources
In Absolute Values

	$ Mil Cash Op Act	Equity* Financing	$ Mll PP&E Expend	1992 Cash Bal	'88-'92 Avg Annual Inpt Trend	1992 Plant Age	
Group 1:							
MGH	300	.43	492	371	(.009)	5.36	
BWH	400	.33	331	313	(.016)	5.56	
CHC	227	.34	292	449	.012	6.15	
Group 2:							
NMC	212	.28	320	141	.002	6.8	
BI	198	.21	442	117	(.022)	7.6	
NED	105	.10	208	117	(.046)	6.9	
BUMC	103	.27	152	135	(.056)	6.6	
ELZ	129	.28	93	80	.020	8.4	
Group 3:							
BAPT	51	.45	71	32	(.061)	6.8	
BCH	40	.23	185	6	(.033)	13.05	**(1991)
FKR	56	.34	30	46	(.062)	11.5	
CAR	57	.35	27	34	(.061)	10.3	

Cash balances exclude trustee-held only

* ratio of equity to total assets;higher implies less financial risk

** before new construction

Table 6

Share of Financial Resources

Relative to Share of Output

	Adj Pat Days 000	% Tot Adj Days	%Tot Cash Op Act/% tot Adj Days	% PP&E/ % Tot Adj Days	% Cash Bal/ % Tot Adj Days
MGH	389	19.4%	0.85	0.95	1.04
BWH	307	15.3%	1.43	0.82	1.11
BI	212	10.5%	1.03	1.59	0.61
NMC	186	9.3%	1.25	1.30	0.82
BCH	169	8.4%	0.26	0.83	0.04
ELZ	147	7.3%	0.97	0.48	0.60
CHC	130	6.5%	1.91	1.70	3.75
NED	121	6.0%	0.95	1.31	1.07
BUMC	108	5.4%	1.03	1.07	1.36
CAR	105	5.2%	0.60	0.20	0.36
FKNR	71	3.5%	0.89	0.32	0.71
BAP	65	3.2%	0.88	0.84	0.54

adj pat days = 1991 pat days*(Tot GPSR/Inpt GPSR)

GPSR = Gross Patient Services Revenue

Table 7

Share of Patient Discharges
by 1990 Patient Characteristic

	% Total Uninsured	% Boston Residents (1990)	% Total Minorities (1990)
BI	6.2%	12.7%	10.7%
BCH	35.9%	16.1%	30.0%
BWH	12.3%	19.4%	26.0%
CAR	5.5%	8.6%	5.8%
CHC	5.8%	4.2%	7.5%
FKR	1.4%	5.6%	n/a
MGH	15.6%	8.1%	5.4%
NEB	1.4%	1.4%	.9%
NED	2.0%	2.1%	1.6%
NMC	6.3%	5.7%	1.9%
ELZ	3.8%	7.0%	3.6%
BUMC	3.8%	4.7%	5.9%

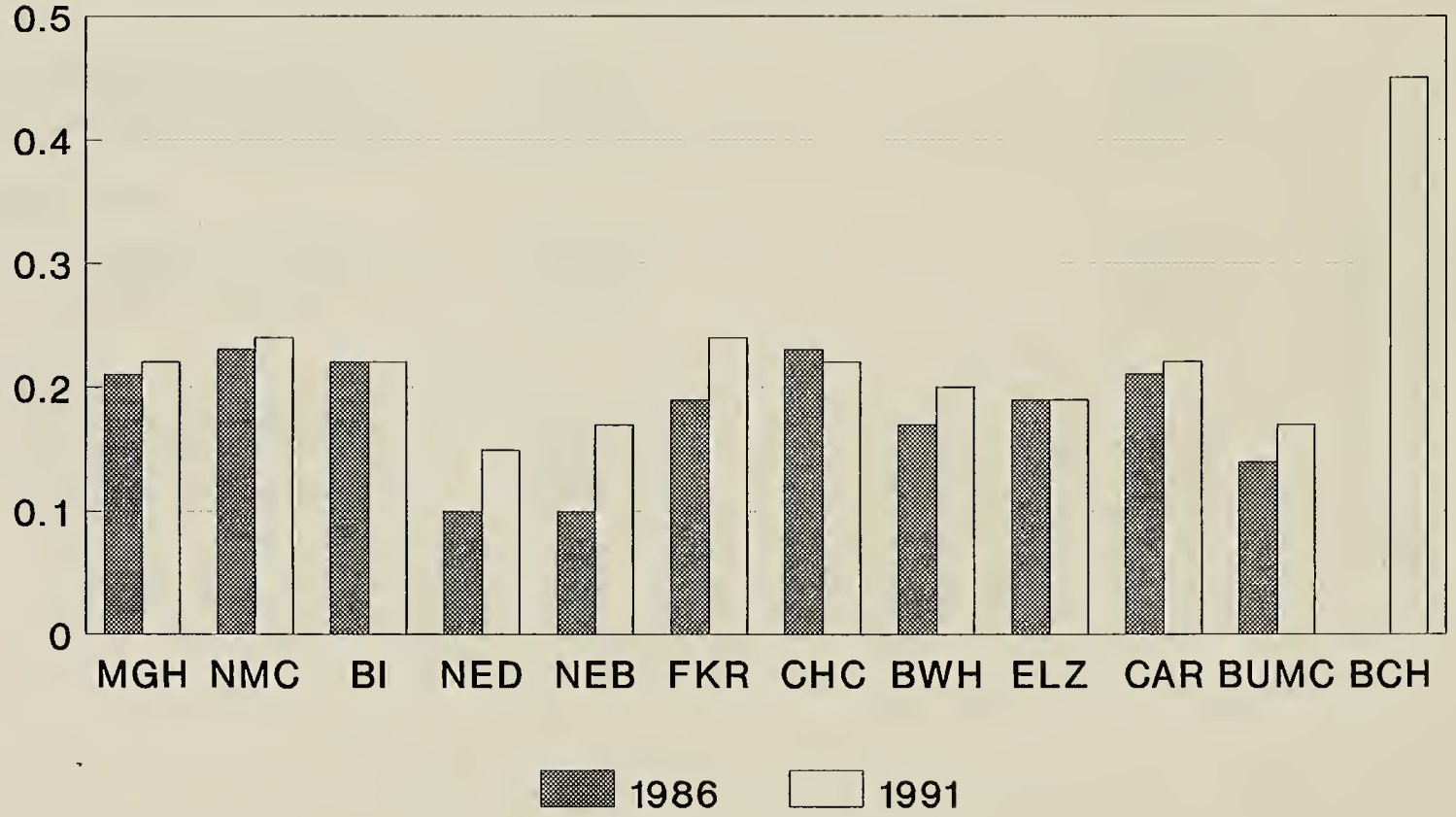
Omits 10% of Boston residents to other hospitals
Uninsured defined as free care & self pay status on patient discharge abstract (MaHDC)

Table 8
Share of Patient Discharges
Relative to Share of Financial Resources

	Share of : Free Care (1991)	Boston Residents (1990)	Minorities (1990)
BI	.57	1.17	.99
BCH	16.9	7.32	13.26
BWH	.56	.89	1.18
CAR	1.77	2.77	1.87
CHC	.46	.34	.60
FKR	.45	1.80	n/a
MGH	.95	.49	.33
NEB	.50	.50	.53
NED	.35	.37	.28
NMC	.54	.49	.16
ELZ	.54	.98	.50
BUMC	.68	.83	1.05

Omits 10% of Boston residents going to other hospitals
Financial resources = 9 years cash from operating activities

Figure 11
Outpatient Share of Total Revenue
1986 to 1991



Source: Medicare Cost Report

Table 9
Outpatient Patient Characteristics

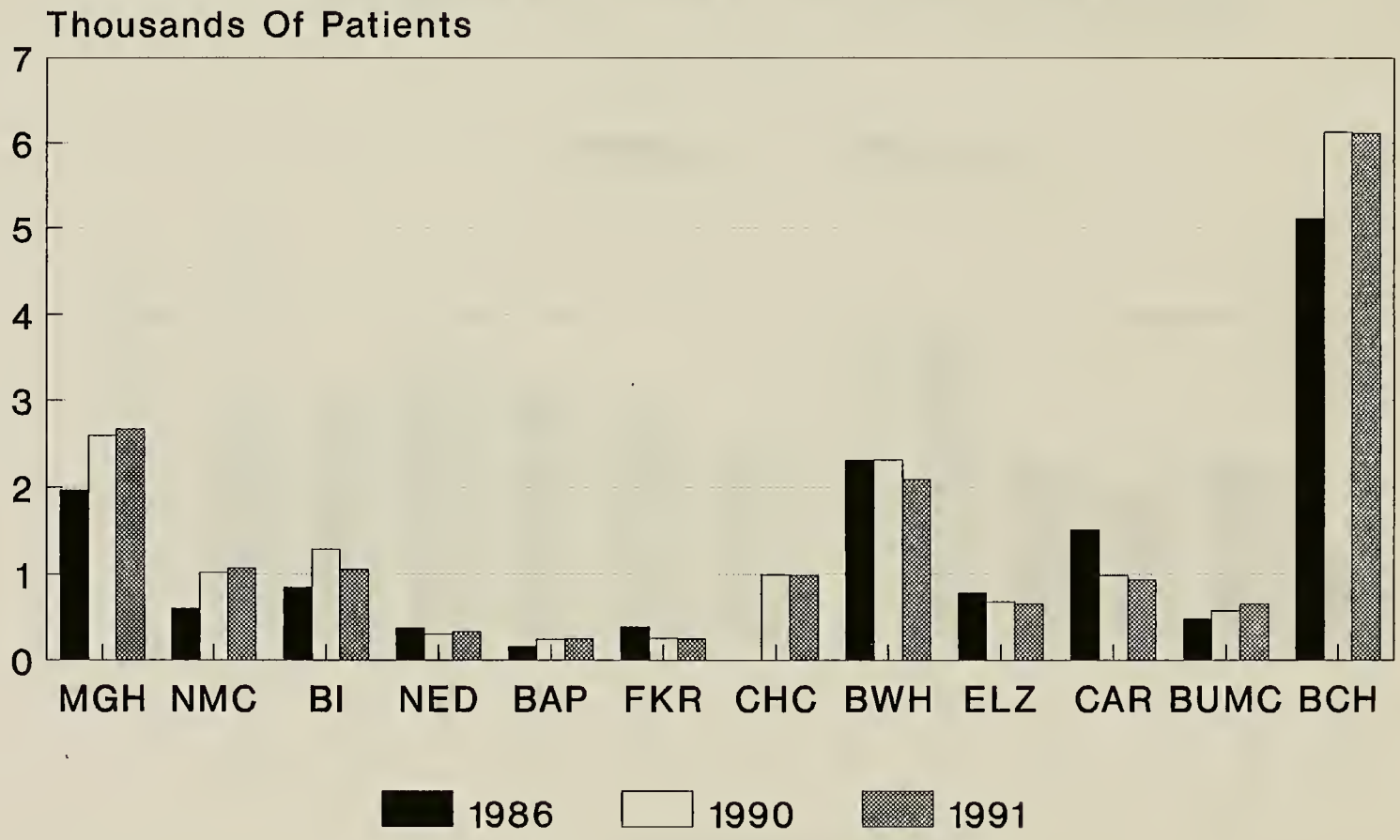
Hospital	Medicaid & Uninsured	Boston Residents
MGH:		
% Outpatient visits	33%	30% *
% Inpatient discharge	14%	19%
Childrens:		
% Outpatient visits	38%	n/a
% Inpatient disch	28%	22%
Brigham:		
% Outpatient visits	24%	57%
% Inpatient disch	15%	34%

Data from 1991/1992 hospital records

* In addition, a high proportion of outpatient visits are residents of Chelsea & Revere

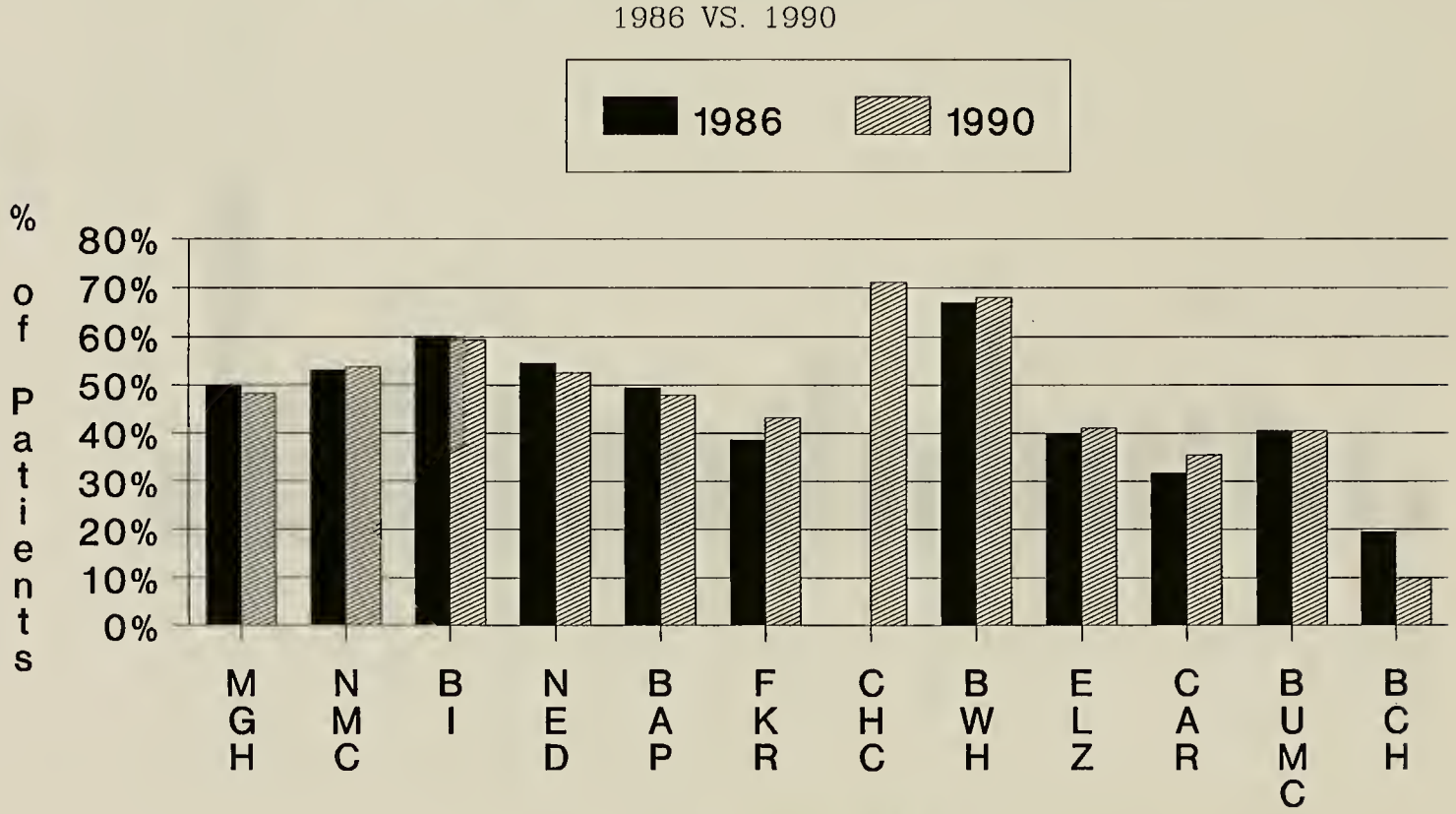
Figure 12

Free/Self Pay Patient Trends



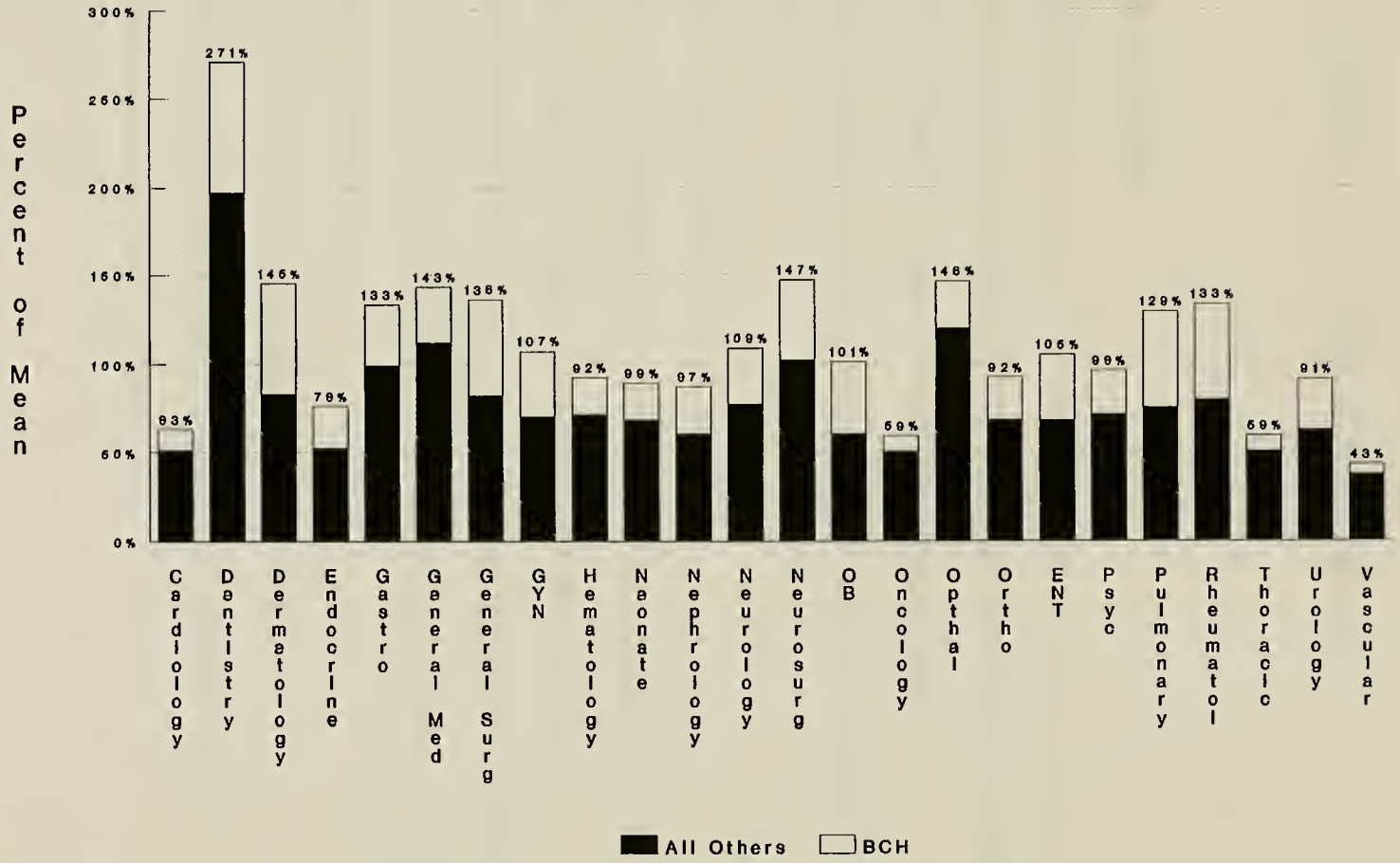
Includes newborns

Figure 13
BOSTON HOSPITALS
PRIVATE PAY PERCENTAGE



Source: MHDC

Figure 14
FREE/SELF PATIENTS - Specialty vs. Mean



Source: MHDC for 1990

APPENDIX A

PRESENTATION OF PRELIMINARY FINDINGS

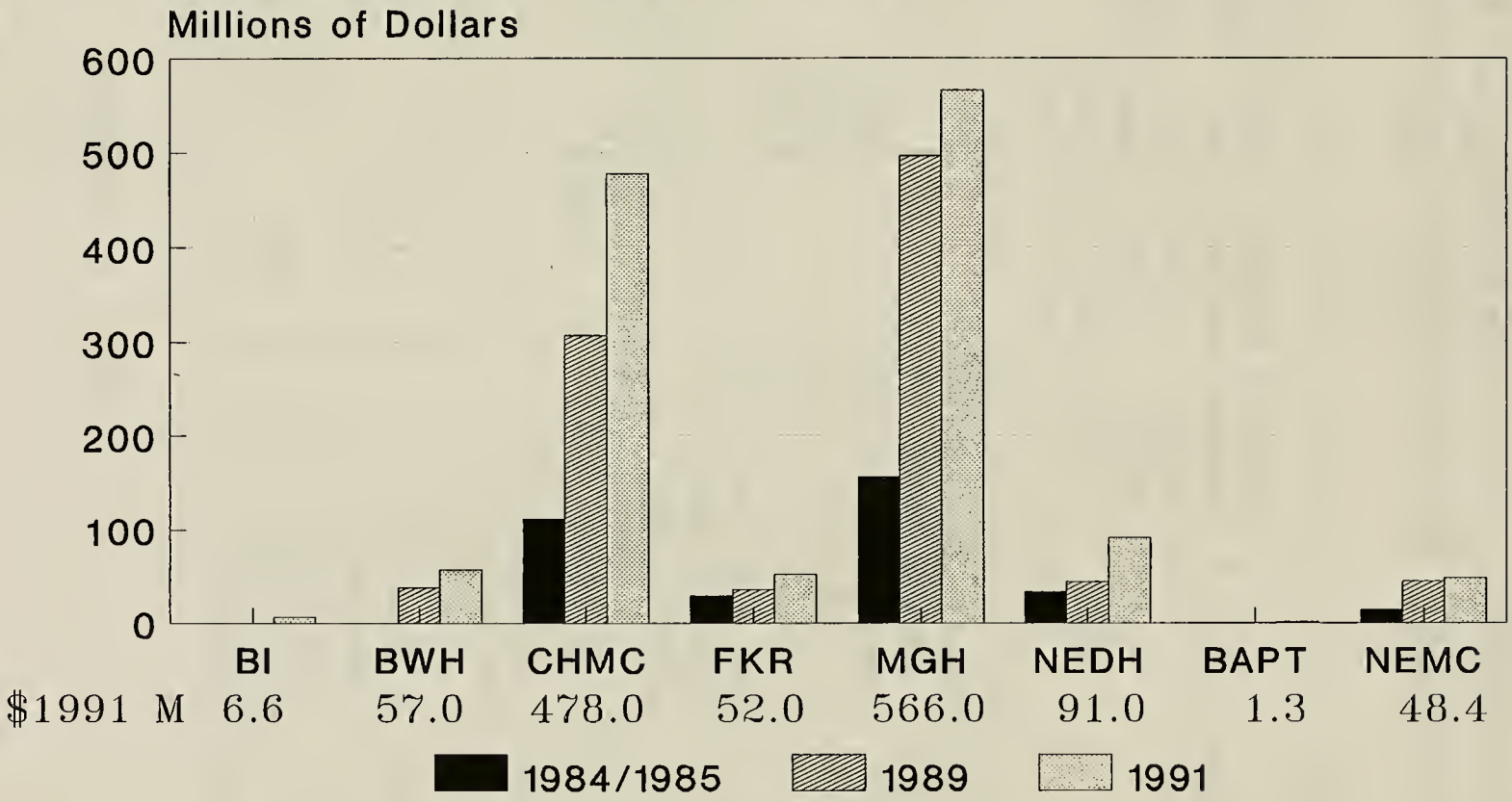
DATES, GROUPS CONSULTED:

11/19/92	FAMILIES USA, BOSTON FOUNDATION, HEALTH CARE FOR ALL
11/24/92	ASSOCIATED INDUSTRIES OF MASSACHUSETTS/GORDON CENTER
11/25/92	MAYOR'S HEALTH CARE COMMISSION/MINTZ-LEVIN
12/7/92	BOSTON ORGANIZATION OF TEACHING HOSPITAL FINANCIAL OFFICERS
12/17/92	BOSTON CITY OFFICIALS/CITY HALL
1/13/93	EXECUTIVE COMMITTEE, MAYORS HEALTH COMMISSION, BCH
1/22/93	OFFICE OF THE ATTORNEY GENERAL, INTERNAL STAFF
2/22/93	MASSACHUSETTS LEAGUE OF COMMUNITY HEALTH CENTERS
2/23/93	ALLIANCE OF COMMUNITY HEALTH LEADERS ASSEMBLED BY HEALTH CARE FOR ALL
2/26/93	COUNCIL OF BOSTON TEACHING HOSPITALS
3/4/93	EXECUTIVE OFFICE OF HUMAN SERVICES, RATE SETTING COMMISSION, WELFARE STAFF

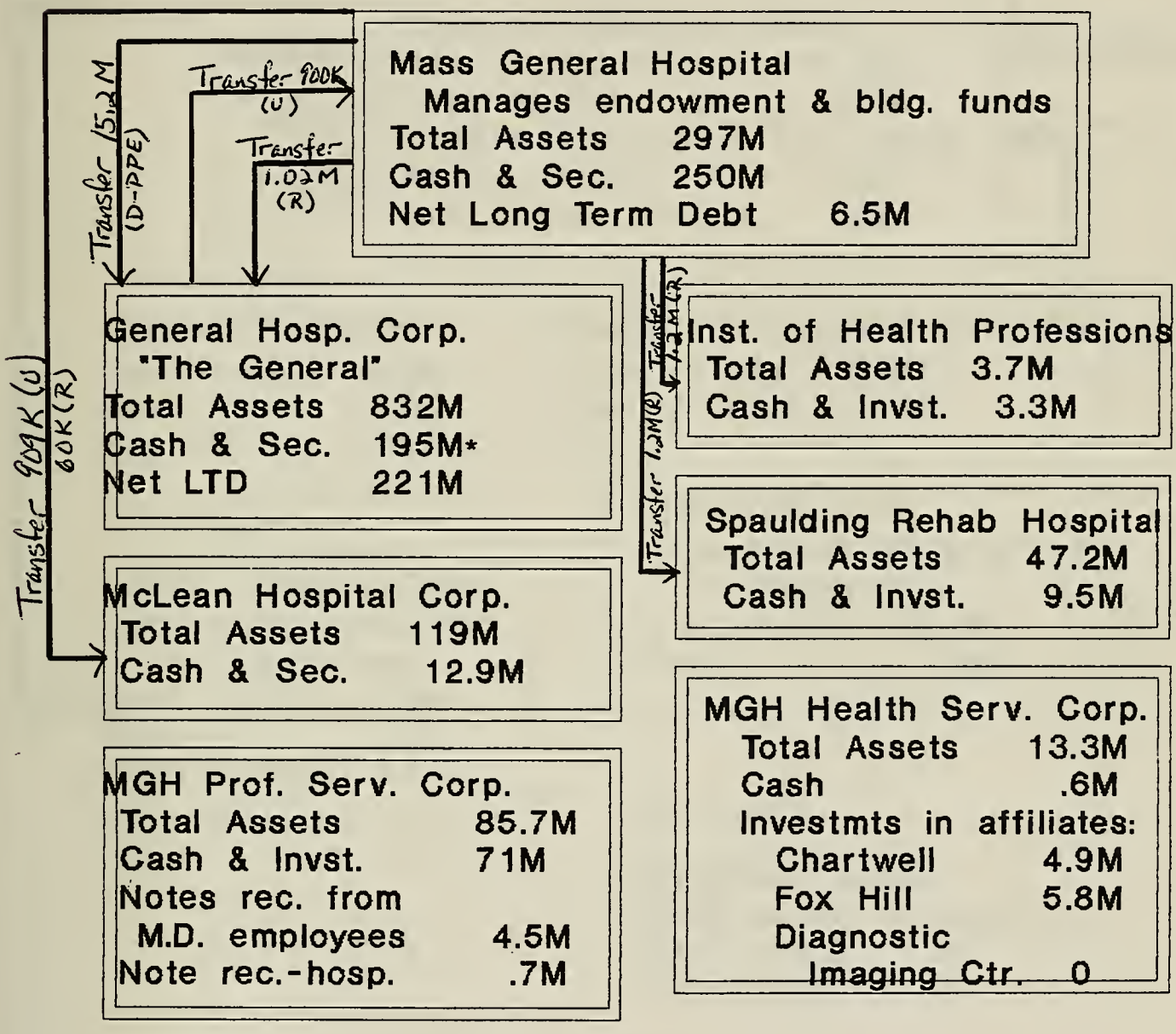
APPENDIX B

AFFILIATE ENTITIES

Appendix B
Affiliate Assets, Historical View
Boston Hospitals



MGH Organizational Structure
and Significant Interaffiliate Transactions

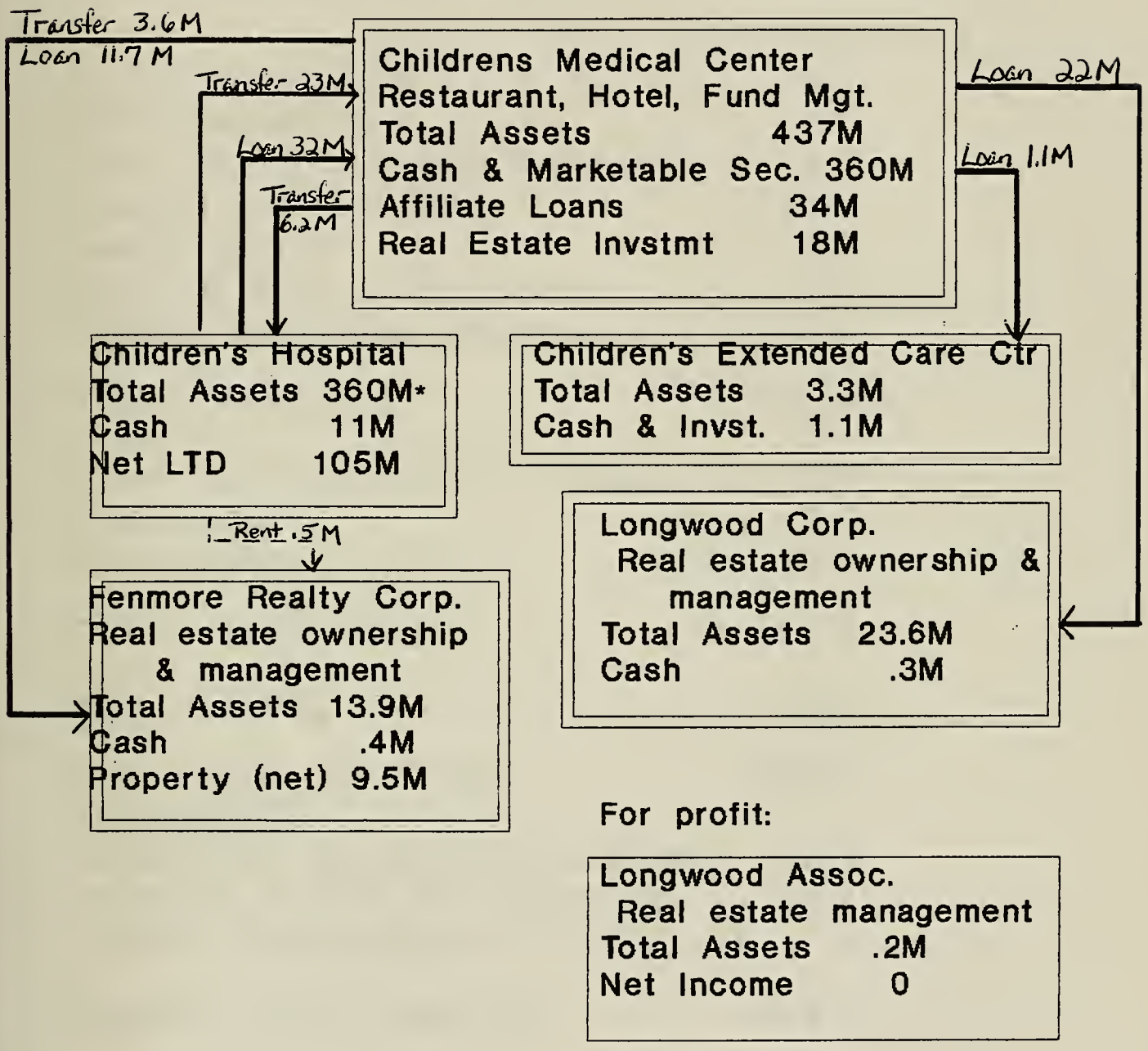


* Excluding investment in CRICO

990s for year ending 9/30/91

U = General Unrestricted Funds
R = Restricted Funds
D = Board Designated Funds

Children's Structure and Significant Interaffiliate Transactions



For profit:

Longwood Assoc.
Real estate management
Total Assets .2M
Net Income 0

990's for year ending 9/30/91

Form 990 Income Statement and Changes in Fund Balance, Childrens Med Ctr (parent)

	$ millions
Unrestricted Gifts	4.7
Restricted Gifts	1.6
Hotel and Restaurant Revenues	4.9
Interest and Dividends	21.7
Rental Income	2.9
Gain on Sale of Securities	8.1
Parking and Other Revenues	.4
TOTAL REVENUE	45.341
Hotel and Restaurant Expense	4.3
Management	1.7
Fundraising	1.0
TOTAL EXPENSE	7.0
NET INCOME	38.3
BEG FUND BALANCE*	349.5
TRANSFERS:	
HOSPITAL DEPRECIATION FUND	23.2
DONOR FUNDS TO HOSPITAL	(6.2)
OTHER TRANSFERS OUT (TO ?)	(.5)
ENDING FUND BALANCE	404.2

Beth Israel Hospital
Organizational Structure*

Beth Israel Hospital Corp.
Total Assets 3K
Cash 3K

Beth Israel Hospital Assoc.
Total Assets 386M
Cash & Sec. 128M
Net LTD 155.4M

BI Dept. of Surgery Trust
Total Assets 2.7M
Cash & Sec. 2.2M

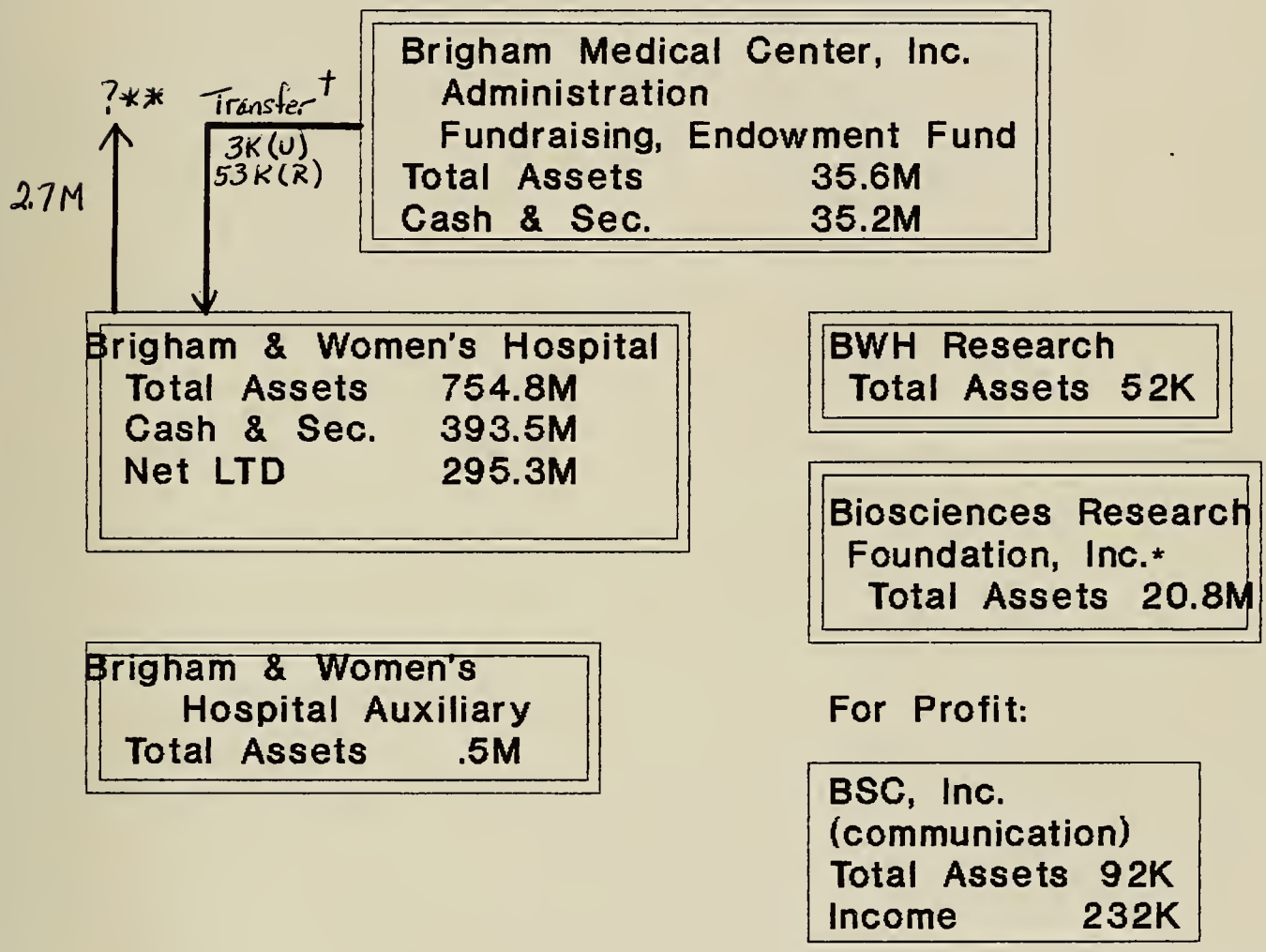
BI OB-GYN Foundation
Total Assets 3.4M
Cash & Sec. 3.3M

Friends of Boston's Beth Israel Hospital
Total Assets 475K
Cash & Sec. 409K

* No transfer of funds between affiliates reported during 1991

990s for year ending 9/30/91

Brigham & Women's Structure and Significant Interaffiliate Transactions



*The sole asset of Biosciences Research Foundation, Inc., is an eight-story building completed in 1984 at a cost $24M. BRF leases this building to BWH as research space.

990's for year ending 9/30/91

** 990 Form reports decrease in fund balance of $2.7M, no explanation found.

† see record of previous years' transfers on next page.

Form 990 Income Statement and Changes in Fund Balance, Brigham Med. Ctr. (parent)

REVENUES	$ 000
Gifts, grants, contributions	$2,058
Program service revenue	1,102
Interest & Dividends	2,699
Gain on Sale of Assets	201
Total Revenue	6,059
EXPENSES	
Program service expenses	2,917
Fundraising	1,012
Total Expenses	3,928
Net Income	2,131
Beginning Fund Balance	27,775
Ending Fund Balance	29,906 **

Fiscal Year Ending 9/30/91

** Audited financial statements indicate a transfer of $56K to BWH not indicated in 990.

Organization of Caritas Christi
Catholic Health Care System

Caritas Christi
Total Assets 1.4M
Cash & Invst. .8M
Invst. in Health
Care Enterprises .1M

St. Elizabeth's Hospital
Total Assets 199.7M*
Net LTD 70.6M

St. Margaret's Hosp. for Women
Total Assets 20.2M*

Other Hospitals in System

St. John of God, Brighton
Cardinal Cushing, Brockton
Holy Family Hospital, Methuen
Good Samaritan Hosp, Brighton

Other entities:

Caritas Christi Support Services
Caritas Christi Diagnostic Service
CC Medical Assoc.
Caritas Christi Information Services
TRACO - Tailored Risk Assurance Co., Inc.
St. Eliz. Hosp. Fnd.

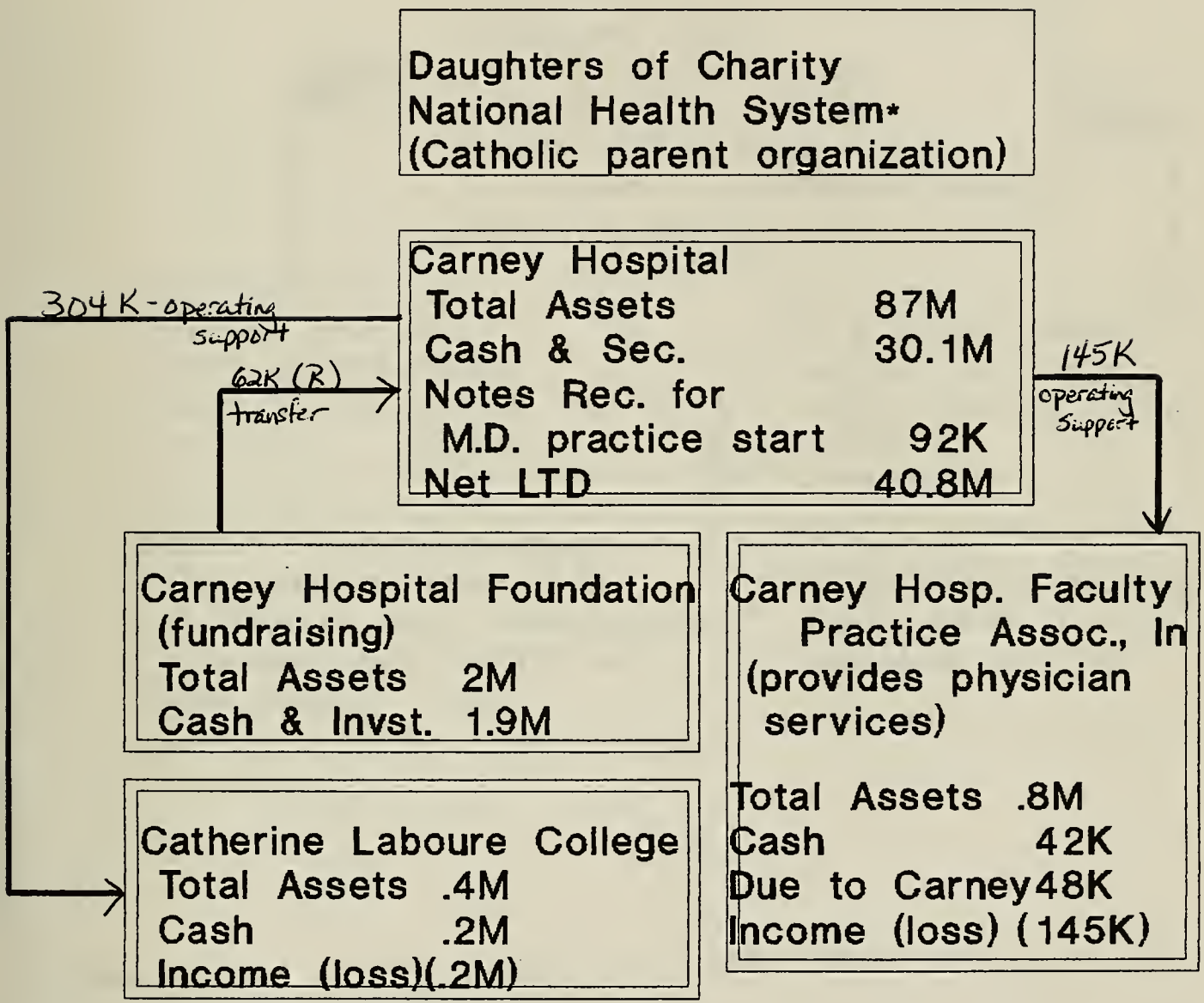
For Profit:

Brighton Marine Med. Assoc.
Health Care Enterprise
BayMed Collection, Inc.
St. Eliz. Realty Corp.

* from audited financial statements

990s for year ending 9/30/91

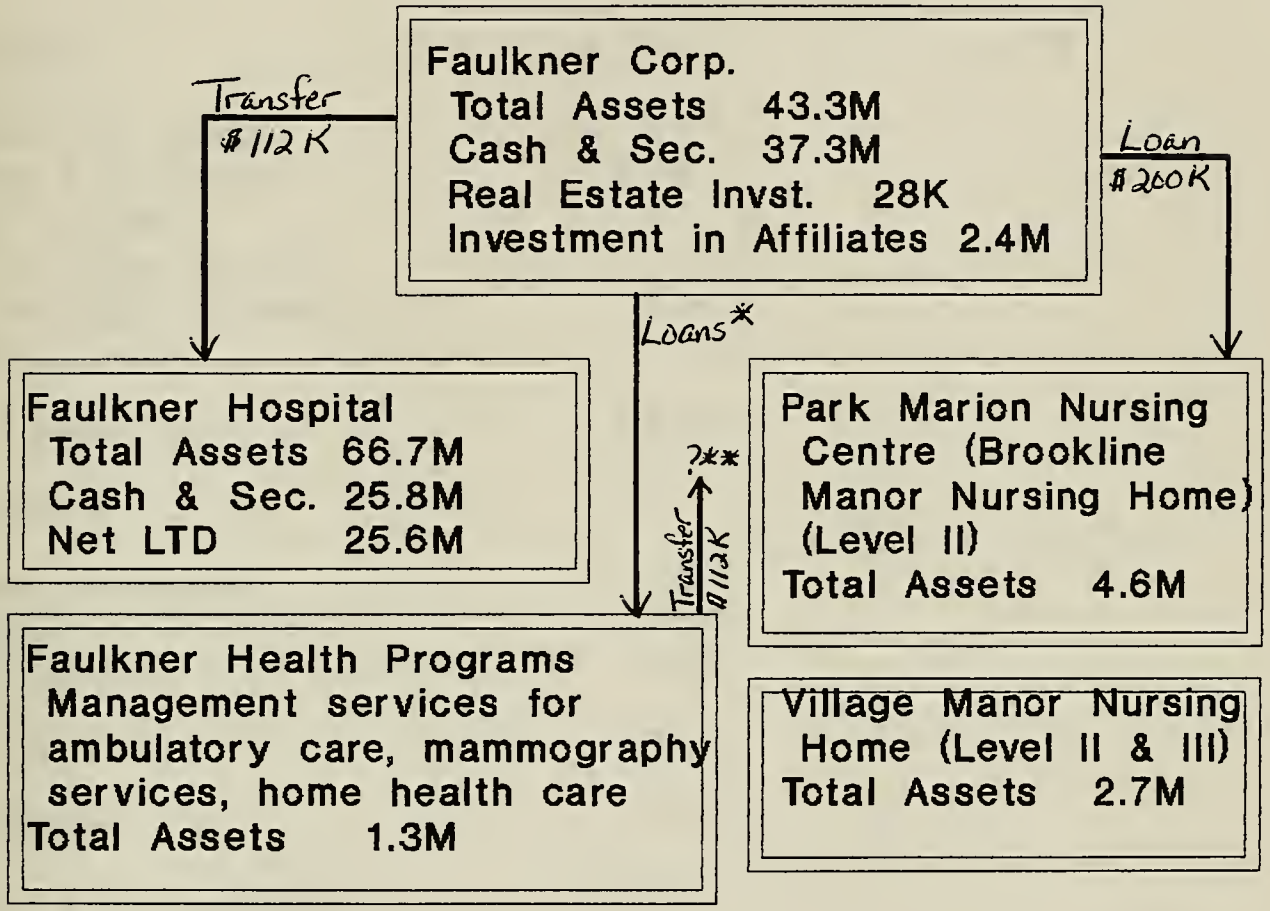
Carney Hospital
Organizational Structure



* Daughters of Charity has no financial linkage with Carney Hospital or its subsidiaries

990s for year ending 9/30/91

Faulkner Hospital Organization
and Interaffiliate Transactions



* Attachment to 990 Form states that Faulkner Health Programs has received working capital loans from Faulkner Corp.: timing and amount are unspecified.

** 990 Form shows decrease in fund balance of $112K with no explanation.

990s for year ending 9/39/91

Income Statem't & Fund Balance Changes, Form 990, Faulkner Corp.

REVENUES	$ 000
Contribution, gifts	$ 476
Interest & Dividends	2,568
Rental Income	61
Gain on sale of sec.	26
Gain on sale of assets	520
Deferred gain	14
Total Revenues	3,665
EXPENSES	
Program services	137
Management & general	2,239
Fundraising	144
Total expenses	2,520
Net Income	1,146
Beginning Fund Balance	37,317
Increase of Endowment Fund Invest. to Market Value	2,895
Ending Fund Balance	41,358

Year ending 9/30/91

New England Baptist Hospital
Affiliates and Significant Transactions

NE Baptist Healthcare Corp.
Total Assets .65M
Cash & Invst. .4M

NE Baptist Hospital
Total Assets 102.4M
Cash & Sec. 28M
Net LTD 33.9M

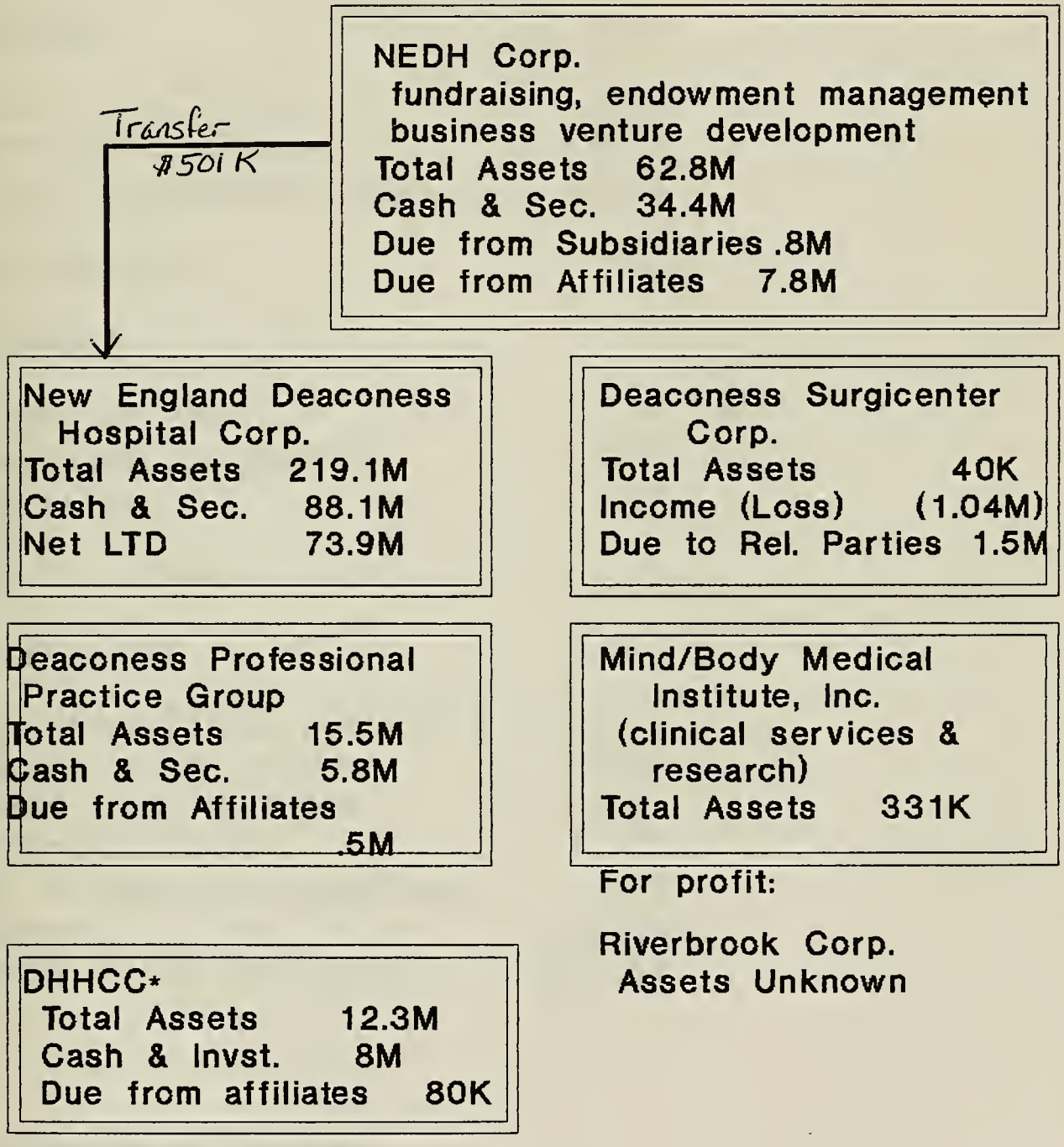
NE Baptist SurgiCare
Total Assets .16M
Cash & Invst. .16M

For profit:

NEB Enterprises
Total Assets .56M
Cash & Sec. .47M
Income .22M

990s for year ending 9/30/91

New England Deaconess Hospital
Structure and Interaffiliate Transfers



990s for year ending 9/30/91

* formerly Deaconess Hospital Home Care Corp.

Income Statement & Changes in Fund Balances, NEDH (parent)

REVENUES	$ 000
Contributions, gifts	776
Investment income	3,686
Parking, management service	3,000
Total Revenue	7,462
EXPENSES	
Program services	1,229
Management & general	4,352
Fundraising	459
Total Expenses	6,039
NET INCOME	1,422
BEGINNING FUND BALANCE	53,654
Legacies, gifts, grants	9,690
Building fund receipts	2,481
Investment income	1,143
Gain on sale of securities	273
Transfers	(9,500)
ENDING FUND BALANCE	59,164

Form 990 for year ending 9/30/91

NEW ENGLAND MEDICAL CENTER STRUCTURE
September 1991 990's

New England Med Ctr, Inc
Parent (fundraising & public relations
Total Assets: 18.3 M
Cash & Securities 13.3 M
Notes rec & invstmt in affiliates:
4.3 M

NEMC Hospital
Total Assets: 432 M
Cash & Sec: 199 M
Net Income: 31M

NE Real Estate
Owns 35 Kneeland & Wang
Total Assets: est. $10 M

Community Practice
Owns Home Health Co
with MGH Affiliate
Total Assets:
Net Income: 1.6 M

NE Long Term Care
Pediatric nursing home &
33% of Medford nursing home
Total Assets: 3.2 M
Net Income: .339M

For Profit:

Transition Systems
Computer Software
management consul
Total Assets: 10.5
Net Income: 1.2M

Liability Limited
Risk Management
Services
Total Assets: .5 M
Net Income: .018 M

NEMC Basic Research, Inc not included

Form 990 Income Statement and Fund Balances
NEMC Inc.Fiscal Year ended Sept 30, 1991

	$ 000
REVENUES	
Gifts, grants ,contributions	$3,107
Less Increase in Gift Reserve	(1,108)
Interest Income and Dividends	1,002
Gains on sales of securities	356
Total Revenue	3,357
Increase in Deferred Revenue	256*
Revenues adjusted for Deferral	3,613
Expenses:	
Public Relations and planning for future development	513
Management & General	367
Fundraising	524
Total Expenses	1,404**
Net Income Excl Deferred Rev Adj	1,953
Beginning Fund Balance	14,355
Transfer to NEMC Hospital	(1,830)***
Ending Fund Balance	14,478

* cumulative balance of deferred revenues:3.2 M, of which 2.99 M were added in 1989
**total expenses include $181,500 salare to JH Grossman (also receives salary from other entities)
*** hospital 990 only recognizes incoming transfer from NEMC, Inc, of $275,000

University Hospital Structure*

University Hospital
Total Assets 324.6M
Cash & Sec. 147.9M
Invst. in Doctor's
Office Bldg. 3.1M
Note Rec. from MGH 1.4M
Net LTD 110.8M

Univer Developmt Foundatn
(coordinates construction
projects by & between
hospital and BU)
Total Assets 3.8M

For profit:

Univer, Inc.
(marketing)
Total Assets 41K

* No significant transfers of funds occurred in 1991

990's for year ending 9/30/91

Income Statem't & Fund Balance Changes, Form 990 University Hospital

REVENUES	$ 000
Gifts, grants, contributions	8,582
Patient revenue	152,062
Dividends and Interest	9,257
Rental income	1,681
Other investment income	592
Gain on sale of assets	4,809
Parking, cafeteria, other revenue	4,416
Total Revenue	181,400
EXPENSES	
Program services	144,092
Management & general	20,462
Fundraising	382
Total Expenses	164,936
Net Income	16,464
Beginning Fund Balance	126,903
Ending Fund Balance	143,367

Year ending 9/30/91

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